

No. 89-1048

FILED

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CLERK

In The
Supreme Court of the United States

October Term, 1989

—◆—
FMC CORPORATION

Petitioner,

vs.

CYNTHIA ANN HOLLIDAY

Respondent.

—◆—
On Writ Of Certiorari To The United States
Court Of Appeals For The Third Circuit

—◆—
JOINT APPENDIX
—◆—

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PETITION FOR CERTIORARI
FILED DECEMBER 29, 1989
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The following opinions, judgments and orders may be found in the Appendix to the Petition for Writ of Certiorari:

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RELEVANT DOCKET ENTRIES

In the United States District Court for the Western District of Pennsylvania:

May 16, 1988	Complaint and summons issued.
July 21, 1988	Answer and Affirmative Defenses by Defendant with Jury Demand.
December 2, 1988	Motion for Summary Judgment with Proposed Order by Plaintiff.
December 5, 1988	Motion for Summary Judgment with Proposed Order by Defendant.
December 9, 1988	Pretrial Statement by Plaintiff.
January 6, 1989	Pretrial Statement by Defendant.
January 9, 1989	Response in Opposition to Motion by Defendant for Summary Judgment by Plaintiff.
March 14, 1989	Memorandum Opinion (Bloch, J.).
March 14, 1989	Judgment Order dated 3/14/89 that Plaintiff's Motion for Summary Judgment is Denied, Defendant's Motion for Summary Judgment is Granted.
March 29, 1989	Notice of Appeal from Order dated 3/14/89.

In the United States Court of Appeals for the Third Circuit:

September 11, 1989	Opinion and Judgment issued.
September 22, 1989	Petition for Rehearing filed.
October 5, 1989	Petition for Rehearing denied.
December 29, 1989	Petition for Writ of Certiorari filed.
February 20, 1990	Petition for Writ of Certiorari granted.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

FMC Corporation,)	
a corporation)	
Plaintiff,)	
v.	)	Civil
Cynthia Ann Holliday,	)	Action No.
an individual,)	
Defendant.)	

COMPLAINT

Plaintiff, FMC Corporation ("Plaintiff" or "FMC") by its attorneys, Kirkpatrick & Lockhart, files this complaint seeking a declaratory judgment pursuant to 28 U.S.C. § 2201. In support of its claims, FMC avers as follows:

PARTIES

1. FMC Corporation is a corporation organized and existing under the laws of Delaware and having its principal place of business at 2000 E. Randolph Drive, Chicago, Illinois 60601.

2. Cynthia Ann Holliday ("Ms. Holliday"), is an individual residing at 1569 Church Street, Indiana, Pennsylvania 15701.

JURISDICTION AND VENUE

3. Jurisdiction over this action is based on 28 U.S.C. § 1332 granting district courts jurisdiction over civil actions where the parties are citizens of different states and

where the amount in controversy exceeds \$10,000, exclusive of interest and costs. There is complete diversity of citizenship between FMC and Ms. Holliday and the amount in controversy exceeds \$10,000, exclusive of interest and costs. Jurisdiction is also based on 28 U.S.C. § 2201 providing for declaratory judgments. FMC's cause of action and its request for declaratory judgment arise under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*

4. Venue is proper in this court pursuant to 28 U.S.C. § 1391 because the defendant resides, and the claim involved in this matter arose, in this district.

FACTUAL BACKGROUND

5. At all times relevant to this matter Gerald S. Holliday, the father and legal guardian of Ms. Holliday, has been employed by FMC. Mr. Holliday, during his employment, has subscribed to the FMC Salaried Health Care Plan ("Health Plan").

6. FMC is the fiduciary of the Health Plan for purposes of 29 U.S.C. § 502(a)(3) of ERISA and is, as a result, a proper party to bring this action. 29 U.S.C. § 1132(a)(3).

7. The Health Plan is filed with the U.S. Department of Labor under Plan No. PN540. The Health Plan is self-funded. (A copy of the Health Plan is attached hereto as Exhibit A.).

8. The Health Plan is an employee welfare benefit plan within the meaning of 29 U.S.C. § 3 of ERISA since it was established and is maintained by FMC, an employer, to provide to beneficiaries medical, surgical and hospital

care benefits in the event of sickness, accident or disability. 29 U.S.C. § 1002.

9. The Health Plan, in addition to providing benefits for FMC employees, also provides health care coverage for the dependents of FMC employees. Those dependents include unmarried children less than 19 years old who reside in the household of the FMC employee. Ms. Holliday at all times relevant hereto was a dependent of Gerald Holliday, and therefore eligible for coverage under the Health Plan.

10. Ms. Holliday was injured in an automobile accident in White Township, Indiana County, Pennsylvania on January 16, 1987. She was the passenger in a car driven by Robert Scott Lyons, a minor residing in Indiana County, Pennsylvania. Lyons lost control of the vehicle he was operating, crossed the line of the roadway and collided head-on with a vehicle coming in the opposite direction.

11. As a result of the accident, Ms. Holliday, who was then 15, suffered severe injuries including a collapsed lung, severe head lacerations and a depressed skull fracture.

12. Since the date of the accident, Ms. Holliday has required intensive and extensive medical care and has incurred medical costs in excess of \$105,000.

13. The Health Plan has provided approximately \$105,000 in benefits to cover the medical expenses incurred by Ms. Holliday.

14. On April 20, 1987, Gerald Holliday, on behalf of Ms. Holliday, commenced in the Court of Common Pleas

for Indiana County, Pennsylvania, a civil action (the "Indiana County action") against Robert Scott Lyons, the driver of the vehicle in which his dependent was riding at the time of her serious injury. The complaint in that action (a copy of which is attached hereto as Exhibit B) alleges that the defendant, Lyons, was negligent in his operation of the vehicle in which Ms. Holliday was a passenger.

15. The Health Plan provides that claims paid pursuant to the Plan are subject to subrogation. In accordance with that provision, FMC contacted in or about October 1987 Thomas G. Johnson ("Johnson"), the attorney representing Ms. Holliday in the Indiana County action referred to herein. FMC informed Johnson that it expected to exercise its subrogation rights with regard to any award received by Ms. Holliday in connection with the Indiana County action.

16. FMC, in its capacity as the fiduciary of the Health Plan, had a responsibility to make this contact in connection with the orderly administration of the Health Plan and in accordance with the ERISA law and the public policy behind it which promote the establishment and maintenance of employee benefit plans.

17. Johnson informed FMC at that time that he would not accede to FMC's exercise of its subrogation rights, stating that under the Pennsylvania Motor Vehicle Financial Responsibility Act of 1984 (the "Act"), 75 Pa.C.S.A. §§ 1701 *et seq.*, medical providers such as FMC were prohibited from exercising subrogation rights with respect to an award received by an injured party as a

result of an automobile accident. Despite numerous attempts by FMC to dissuade Johnson of the validity of this position, Johnson, on behalf of Ms. Holliday, has clung to the position that the Act, at § 1720 relating to subrogation, precludes FMC from exercising its subrogation rights.

COUNT I

The Employee Retirement Income Security Act Preempts the Application of the Subrogation Section of the Pennsylvania Motor Vehicle Financial Responsibility Act of 1984

18. The averments of paragraphs 1 through 17 are incorporated by reference as though set forth at length herein.

19. Despite repeated demands, Johnson, on behalf of Ms. Holliday, has refused to accede to FMC's rightful exercise of its subrogation rights. Johnson in taking this position has relied on § 1720 of the Act relating to subrogation. That section provides:

In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under § 1711 (relating to required benefits), § 1712 (relating to availability of benefits) or § 1715 (relating to availability of adequate limits) or benefits in lieu thereof paid or payable under § 1719 (relating to coordination of benefits).

20. The ERISA statute at 29 U.S.C. § 514(a) contains a broad preemption clause which states that "the statute shall supersede any and all state laws insofar as they may

now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a).

21. The ERISA statute at § 514(b)(2)(A) also contains an insurance savings clause which broadly states that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking or securities." 29 U.S.C. § 1144(b)(2)(A).

22. However, a single exemption to the "savings clause" is found in § 514(b)(2)(B), the so-called "deemer clause," which states that no employee benefit plan "shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies or investment companies." 29 U.S.C. § 1144(b)(2)(B).

23. The "savings clause" and the "deemer clause" of the ERISA statute, when read together, represent Congress' intent to preempt any state law which attempts or purports to regulate a self-insured medical plan.

24. The Health Plan is such a self-insured plan.

WHEREFORE, in light of the fiduciary's responsibility under ERISA to enforce the provisions of an employee benefit plan, FMC respectfully requests that this court enter judgment in favor of FMC as follows:

(a) declaring that ERISA preempts the subrogation section of the Act (75 Pa.C.S.A. § 1720) as it applies to a self-insured plan, such as FMC's Health Plan;

(b) declaring that FMC, as a result, may exercise its subrogation rights;

(c) directing Johnson, on behalf of Ms. Holliday, to cooperate with and otherwise facilitate FMC's exercise of its subrogation rights; and

(d) granting such further relief as this court deems just and proper, including FMC's costs and attorneys' fees.

COUNT II

The Act's Subrogation Section is Not Meant to Reach Medical Providers Such as FMC

25. The averments of paragraphs 1 through 24 are incorporated by reference as though set forth at length herein.

26. The Act at § 1720, relating to subrogation, provides that there shall be no subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits or benefits available under § 1711, § 1712, § 1715 or § 1719. (A copy of Subchapter B of the Act, in which these provisions appear, is attached hereto as Exhibit C.)

27. Sections 1711, 1712, and 1715 of the Act specifically limit their coverage to policies provided by an insurer issuing or delivering liability insurance policies covering any motor vehicle of the type required to be registered under the Act. At § 1702, the Act defines insurer or insurance company as a motor vehicle liability insurer subject to the requirements of the Act. (A copy of § 1702 is attached hereto as Exhibit D.)

28. Section 1719 of the Act relates to the coordination of benefits, stating that except for worker's compensation, a policy of insurance issued or delivered pursuant to Subchapter B shall be primary. The Section adds that any program, group contract or other arrangement for payment of benefits such as described in Sections 1711, 1712 and 1715 shall be construed to contain a provision that all benefits provided therein shall be in excess of and not in duplication of any valid and collectible first party benefits provided in Section 1711, 1712 or 1715.

29. Further, Section 1719(b) of the Act defines "program, group contract or other arrangement" as including, but not being limited to, benefits payable by a hospital plan corporation or a professional health service corporation subject to 40 Pa.C.S.A. ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services corporations).

30. Nowhere in Sections 1711, 1712, 1715 or 1719 does the Act contemplate or specifically refer to a health plan such as FMC's which is self-insured.

31. The absence of such a reference in Subchapter B of the Act comports with federal public policy, as reflected in the ERISA statute, in favor of the establishment and maintenance of employee welfare benefit plans such as FMC's Health Plan.

WHEREFORE, FMC respectfully requests that this Court enter judgment in favor of FMC as follows:

(a) declaring that § 1720 relating to subrogation does not cover self-insured plans such as FMC's Health Plan;

(b) declaring that FMC is entitled to exercise its subrogation rights in this matter;

(c) directing Johnson on behalf of Ms. Holiday to cooperate with and otherwise facilitate FMC's exercise of its subrogation rights; and

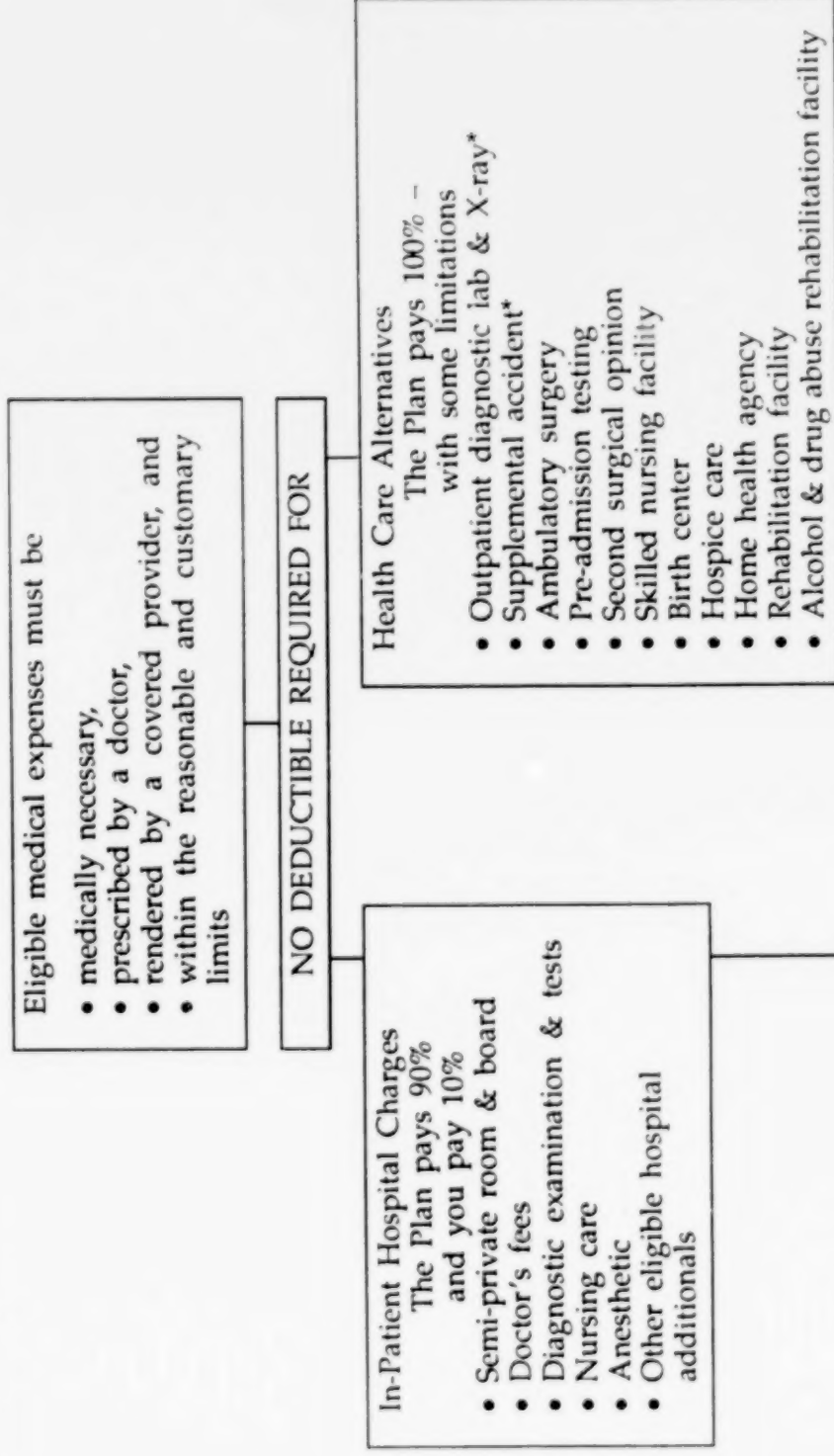
(d) granting such further relief as this Court deems just and proper, including FMC's costs and attorneys' fees.

Dated: May 16, 1988

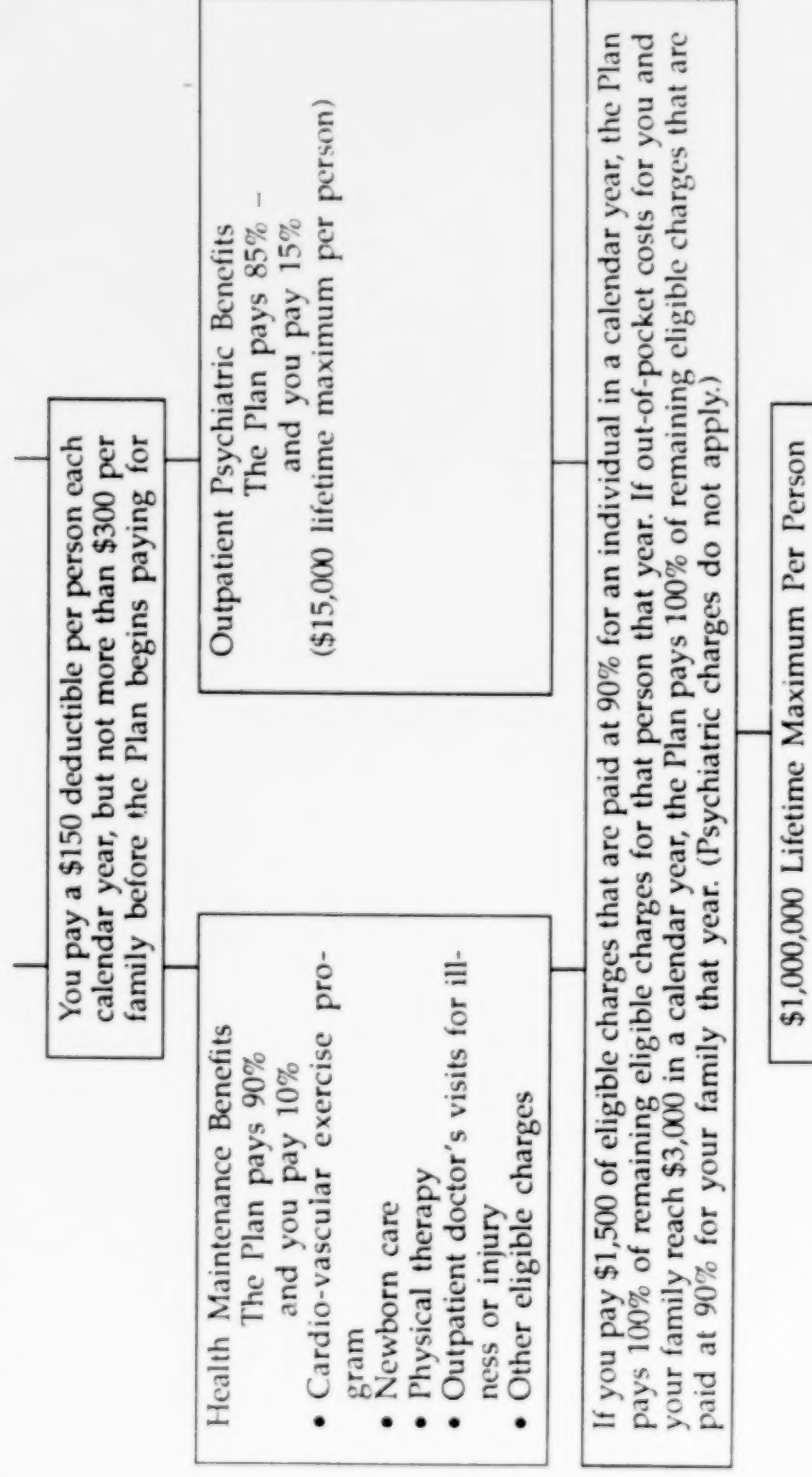
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Summary of Your FMC Salaried Health Care Plan Benefits

Here's a summary of how the Health Plan helps pay eligible medical expenses for an individual during a calendar year.



*\$1,000 maximum. Excess at 90%, after deductible.



The information in this section applies to salaried and non-union hourly employees at designated locations.

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*The page numbers in this Table of Contents originally corresponded to the pages of the Health Plan booklet. For purposes of convenience, the page numbers have been changed to correspond to the pages of this Joint Appendix.

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YOUR HEALTH CARE BENEFITS – A SUMMARY

To make good health care affordable.

The increasing cost of good medical care and treatment is a probable shared by all of us. Medical care costs in recent years have risen at a considerably faster pace than the prices for most other major family expenses. As a result, family finances could be seriously depleted by the medical expenses resulting from a severe accident or illness. Even the cost of some routine health care can be a short-term monetary problem. FMC health care benefits are designed to help you and your eligible dependents meet the financial impact of continually increasing medical costs.

The summary of benefits chart at the beginning of this section shows how the FMC Health Care Plan furnishes protection against most medical expenses that you and your family are likely to incur. There are four major parts to your FMC Health Care Plan:

In-Patient Hospital Benefits

In-patient hospital benefits cover medically necessary charges for such items as room and board, drugs, doctor's fees and tests while you or your eligible dependents are confined in a hospital. The Plan pays 90% of eligible charges related to a hospital confinement, including any surgeon's fees. You pay the remaining 10%. There is no deductible requirement. There are limitations on confinements for psychiatric care, alcohol and drug abuse rehabilitation, skilled nursing care and comprehensive rehabilitation.

Health Care Alternatives

There are several options available to help you avoid a costly hospital confinement. There is no deductible requirement for Health Care Alternatives. Your Plan covers these specialized facilities at 100% – with some limitations:

- Alcohol and drug abuse rehabilitation facility
- Rehabilitation facility
- Hospice care
- Skilled nursing facility
- Home health care
- Birth centers

The Plan also covers these Health Care Alternatives at 100%:

- Pre-admission testing
- Ambulatory, out-patient or same day surgery
- Second surgical opinion

If you require out-patient diagnostic x-rays and/or laboratory tests, the Plan pays 100% up to the first \$1,000 of charges. After the calendar year deductible is satisfied, the Plan then pays 90% for any additional charges.

Any accident-related charges on an out-patient basis (with the exception of chiropractic charges), if incurred within 90 days of the accident, are paid at 100% up to the first \$1,000 of eligible charges per accident with no deductible.

Health Maintenance Benefits

This section of the Plan covers a wide range of health services such as out-patient doctors' visits, prescription drugs and cardio-vascular exercise programs. A deductible is required before the Plan begins paying benefits. This means you pay the first \$150 of expenses each calendar year, or \$300 for family members eligible under this Plan. After the deductible is satisfied, the Plan will pay 90% of all the reasonable and customary charges for the rest of that calendar year. Out-patient psychiatric charges, covered under this provision, are payable at 85% of eligible charges, subject to a \$15,000 life time maximum.

Catastrophic Coverage – Maximum Benefits

Your Plan provides a \$1 million lifetime maximum benefit for you and each covered dependent in your family. In addition, once you pay \$1,500 per individual (\$3,000 maximum per family) per calendar year for eligible medical expenses which are normally covered at 90%, the Plan will pay 100% of those charges for the remainder of the calendar year.

It is important to note that charges for psychiatric care do not apply to the out-of-pocket maximum. You will always share in the cost of psychiatric care.

The Plan pays benefits for most non-occupational injuries and diseases. For work-related injuries and illnesses, there is no coverage under this Plan. See your local Human Resources representative for information on work-related accident or illness.

The following pages provide more details about your Health Care Plan.

ESSENTIAL PLAN INFORMATION

Effective Date

All of the information in this section is effective as of August 1, 1987.

Eligibility – You

You are eligible to participate in the Medical Care Plan on the first day of the month coinciding with or next following the completion of a full calendar month of employment. To be eligible, you must also be:

- a salaried or non-union hourly full-time employee.
- employed by an FMC location that offers this Plan.
- not covered by a collective bargaining agreement.

To enroll, you must fill out the enrollment form provided by your Human Resources Department. If you wait more than 31 days after you are first eligible, you must furnish satisfactory proof of your good health at your own expense.

Coverage will become effective upon approval by the Claim Administrator. (You will also have to submit proof of good health if you are reapplying for coverage after your coverage has terminated for any reason except a change in your employee status.)

If you are absent from work on the day on which your coverage would normally begin, you will become covered on the day you return to active work.

Any person covered under a Health Maintenance Organization (HMO) paid by FMC, is not eligible for benefits under this or any other FMC Health Care Plan.

Eligibility – Your Dependents

Dependents who are eligible for coverage under this Plan include:

- your spouse (unless legally separated),
- your unmarried children (related by marriage, parentage or law) less than 19 years old, and
- your unmarried children age 19 or over but less than age 23 who are full-time students, and
- mentally retarded or physically handicapped children 19 years old or older who are unmarried, incapable of self support and chiefly dependent on you for maintenance and support – as long as they were covered as your dependents under this Plan before the age of 19. To continue either a mentally retarded or physically handicapped child's coverage, you must apply to the Claim Administrator no later than 31 days before the child's 19th birthday. If continued coverage is approved, you will be asked periodically to furnish proof of your child's continuing disability.
- children for whom the employee has not assumed legal responsibility, such as children of married participants who have a child born outside of their marriage, will not be covered.

Eligible children, who meet the criteria above, must reside in your household in a parent/child relationship and/or be dependent upon you for support and maintenance. You will be asked periodically to furnish proof of your child's eligibility. This proof may consist of academic grade transcripts, course enrollment schedules or copies of Federal income tax returns. Full-time students are defined as those students who are enrolled in academic programs fulfilling 12 or more semester hours of credit.

No person is eligible as a dependent if eligible as an employee for this or any other FMC Health Care Plan, including an HMO. If you and your spouse are both covered for health care plan benefits as FMC employees, you and your spouse must choose the health care plan (including HMO's) under which the children will be covered as eligible dependents. The children can be enrolled in one of the spouses' health care plans, but not both. In addition, eligible children can participate in only one of the spouses' health care plans, not both. In other words, eligible children cannot be "split-enrolled" among the spouses' plans.

To cover your dependents under this Plan, you must complete an enrollment form indicating their eligibility. Their coverage will begin on the first day you are eligible to participate. If you do not enroll eligible dependents within 31 days of the time they are first eligible, they must furnish satisfactory proof of good health at their own expense in order to obtain coverage. Coverage will become effective upon approval by the Claim Administrator.

A dependent who is confined to the hospital (except at birth) must wait until the confinement ends to become covered under this Plan.

COST

FMC Corporation pays the full cost of this Plan.

DEFINITIONS

Reasonable and Customary

Reasonable and customary charges means the fee charged by the provider for a service rendered or a supply furnished but only to the extent that the fee is reasonable, taking into consideration the following:

- The usual fee which the provider most frequently charges the majority of patients for the service or supply,
- The prevailing range of fees charged in the same area by providers of similar training and experience for the service or supply, and
- Unusual circumstances or complications requiring additional time, skill and experience in connection with the procedure.

The term area means a metropolitan area, a county or such other geographical area or areas as is necessary to obtain a representative cross-section of a provider rendering services or furnishing such supplies.

Charges for services, supplies, or treatments (including unnecessary repetition of tests) that are not reasonable and customary (as determined by the Claim Administrator) will not be paid; you will be responsible for payment. Therefore, when possible, you should determine how the fees and procedures of your doctor and hospital compare with the norm in your region of the country before you made a final decision about where to receive treatment. Your Human Resources Representative can help you make this determination.

Medical Necessity

Eligible charges will be covered only if the Claim Administrator determines them to be medically necessary. The fact that a physician or another provider has furnished, ordered or approved a service does not, of itself, make that service medically necessary. To be medically necessary, a service must be:

1. Consistent with the symptom or diagnosis and treatment of your illness or injury; and
2. Appropriate with regard to standards of good medical practice; and
3. Performed in the least costly setting where services can be solely and appropriately provided; and
4. Not solely for your convenience or that of your physician or the facility at which you receive treatment.

Any charges that cannot be reviewed by the Claim Administrator for medical necessity will not be covered by the Plan.

Doctor and Other Providers of Service

A doctor is a person who is licensed to practice medicine including a chiropractor (see page 34), dentist, osteopath, podiatrist, psychiatrist and psychologist.

This Plan also recognizes the following state licensed allied health professionals as providers who practice under the direction of a legally qualified physician: clinical licensed social worker, speech therapist, physical therapist, licensed practical nurse (LPN), registered nurse (RN) and certified nurse midwife (CNM).

Eligible Charge

An eligible charge means the Plan pays benefits only for reasonable and customary charges that are the result of a non-occupational illness or injury. All charges must be for services or items recommended by a doctor and necessary for medical care.

Prescription Drugs

A prescription drug means any medicinal substance which is required to bear the label "Caution: Federal law prohibits dispensing without prescription". This also includes compounded medications which contain at least one such medicinal substance. Contraceptive medications are excluded.

Hospital

A hospital is a legally operated institution, approved by the Joint Commission on Accreditation of Hospitals, that provides care through organized diagnostic and surgical facilities. Supervision by a staff of doctors and a 24-hour-a-day service by registered nurses must be available. The term "hospital" does not include an institution, or part of one, used mainly for rest care, nursing care, convalescent care, care for the aged, care of the chronically ill, educational care or custodial or maintenance care that cannot reasonably be expected to substantially improve a medical condition. Charges from an institution which is not considered a hospital are not eligible for payment. (There is a special coverage for ambulatory surgical facilities, rehabilitation hospitals, alcohol and drug abuse facilities,

and skilled nursing facilities. See page 16 for specific Plan provisions and limitations.)

Ambulatory Surgical Center

A surgical center is a facility equipped to handle surgical procedures that require hospital facilities but do not require a hospital stay.

In order to qualify, a surgical center must be established, equipped and operated for the performance of surgical procedures by doctors. It must have an organized medical staff; equipment and supplies not usually available to a doctor outside a hospital, including operating rooms, a recovery room, diagnostic facilities, and emergency equipment, full-time registered professional nurses, and a written agreement with a nearby hospital to accept patients who develop complications.

Local Ambulance Service

Local ambulance service is medically necessary ambulance transport to the nearest hospital providing emergency medical care. This also includes non-emergency transportation such as to a rehabilitation hospital, skilled nursing facility or transfer to home during a terminal phase of illness as long as the transportation is medically necessary.

Pain Center

A pain center is a licensed facility with trained and licensed personnel-capable of evaluating, managing and

treating a variety of chronic pain syndromes. (See page 33 for specific Plan provisions and limitations.)

Home Health Agency

A home health agency is a public or private agency or organization, or part of one, that mainly provides skilled nursing and other therapeutic services. It must be legally qualified in the state or locality in which it operates. It must keep clinical records on all patients. The services must be supervised by a doctor or registered nurse (R.N.); and they must be based on policies set by associated professionals, which include at least one doctor and one registered nurse. This does not include a home health agency used mainly for the care the treatment of mental, nervous or emotional conditions.

Birth Center

An out-of-hospital, free standing birth center is an ambulatory care facility providing safe, low cost, comprehensive maternity care to healthy families who have participated in sound prenatal screening and care and are anticipating a normal birth. The center is an adaptation of the home rather than a modification of the hospital. Birth centers must meet criteria of the Claim Administrator.

Optional Pre-Treatment Benefit Review

To help you know in advance what medical expenses are covered by the Plan, the Claim Administrator, who handles the payment of benefits, offers a pre-treatment benefit review service. If you or a member of your family is

about to undergo a major, non-emergency medical procedure or a series of treatments, you can use this optional service to find out what benefits the Plan will pay. To do so, obtain a detailed written description of the anticipated services, charges and diagnoses from your physician before the treatment begins. This information should then be forwarded to the Claim Administrator. You should allow at least 30 days for a response.

You'll be advised how the Plan will help you pay for the treatment.

IN-PATIENT HOSPITAL BENEFITS

90% Coverage – No Deductible

Your Plan pays 90% of total eligible charges for expenses as a result of an illness or injury related to hospitalization including:

- Room and board charges for ward, semi-private or the intensive care unit. Private room and board charges are also paid when evidence of medical necessity is submitted by your doctor and concurred with by the Claim Administrator. (If you stay in a private room by your own choice, the Plan pays a rate equal to the hospital's most common charge for a semi-private room. You must pay the cost difference between a semi-private and private room.)
- Reasonable and customary doctor's fees
- Diagnostic examinations and tests when they are related to the illness or injury causing hospitalization
- Prescription drugs and medications
- Nursing care (includes hospital staff nurses, but does not include private duty nursing care)
- Use of the operating, recovery and delivery rooms

- Anesthetics and their administration
- Physical therapy
- Oxygen and its administration
- Dressings, casts, splints
- Radiation therapy
- Administration of blood and blood plasma, also blood, if not replaced by a blood plan
- Medically necessary local ambulance transport
- In-patient psychiatric care is limited to 120 days per person in a 365 consecutive day period beginning with your first day of confinement. Regular progress reports from the doctor to the Claim Administrator will be required to assure that the confinement is medically necessary.
- In-patient care for alcohol or drug dependency is covered at 100% up to the first 30 days of confinement. A second admission is covered at 50% for up to 30 days of confinement. A confinement may be less than 30 days, however, charges incurred in excess of 30 days for each confinement are not covered. There is a lifetime maximum of two covered confinements per person.

Benefits are not paid for personal convenience items, such as television, telephone, admission kits.

Non-Emergency Week-end Admission Limitation

If you or an eligible dependent is admitted to the hospital on a Friday or Saturday, no benefits are payable for any hospital-related expenses incurred during that first week-end (Friday, Saturday, Sunday.) However, full Plan benefits are payable to you if you are admitted because of an emergency or if surgery is being performed that week-end. An emergency means a sudden, unexpected medical

condition that, without immediate medical attention, could result in death or cause impairment to bodily functions.

Doctor's Charges Related to Hospital Confinement

The Plan will pay 90% of the reasonable and customary doctor's charges (no deductible) for treatment while you are confined in the hospital.

Maternity Benefits

Maternity benefits are payable to employees and eligible dependents if pregnancy related expenses occur while coverage under this Plan is in effect.

Hospital Delivery – If you are confined to a hospital, expenses related to your maternity care are paid at 90%. This includes:

- Hospital room and board
- Hospital additional
- Reasonable and customary doctor's fees
- Prenatal and postnatal care (including prescription drugs)

Birth Center – If you receive maternity care in a birth center, the Plan pays 100% of the covered charges. (See Health Care Alternatives, page 19.)

If you terminate employment with FMC and you or an eligible dependent is pregnant, health coverage, including maternity coverage, ceases on the day you terminate employment. (Of course, you can insure continued coverage by electing health care continuation coverage as explained on page 55.)

Surgery Charges

In-Patient Surgery – If you receive surgery while hospitalized, the Plan pays 90% of the reasonable and customary doctor's fees for surgery. The eligible covered charge for an assistant surgeon is 20% of the primary surgeon's reasonable and customary fee.

Ambulatory Surgery (out-patient or same day) – If you receive surgery on an out-patient or ambulatory basis, the Plan pays 100% of the reasonable and customary doctor's fees for surgery. (See "Health Care Alternatives", page 19.)

A second surgical opinion is required for 16 surgical procedures. (See "Health Care Alternatives", page 21.)

Benefits are payable for charges by a doctor of dental surgery (D.D.S. or D.M.D.) only for these cutting procedures for treatment of disease or injury of the jaw:

- Removal of impacted wisdom teeth
- Cutting to realign the jaw bone (osteotomies)
- Repair of dislocated or fractured jaw
- Removal of tumors and cysts
- Restoration for accidental injury to sound natural teeth only if the injury occurred while you were covered under this Plan

Benefits for other dental procedures may be covered under your Dental Care Assistance Plan. Please refer to your Dental Plan description for additional information.

Oral Surgery Hospital Confinement Limitation

The Plan will not pay for any in-patient or out-patient hospital benefits, including anesthesiologist, for any oral surgery unless a medical doctor (M.D. or D.O. – not D.D.S. or D.M.D.) provides evidence, IN ADVANCE, to the Claim Administrator, that hospitalization is medically necessary. Medically necessary conditions include, for example, severe hypertension, severe diabetes or a disabling cardiac condition. You must be admitted by an M.D. or D.O. Apprehension, regardless of age, does not entitle you to benefits for dental admissions. (See Medical Necessity definition, page 12.)

HEALTH CARE ALTERNATIVES

100% Coverage – Some Limitations – No Deductible

A number of approved and licensed health care facilities are available which offer quality, specialized care as an alternative to costly hospital confinement. **Any health care facilities covered under this provision of the plan must be approved by the Claim Administrator as meeting established standards, including any legal licensing requirements of the state or locality in which it operates.**

Your Plan covers the following specialized health care facilities at 100% with some limitations:

Ambulatory Surgery (Out-Patient or Same Day)

The Plan pays 100% of the reasonable and customary doctor's fees for ambulatory surgery versus 90% of the surgeon's fees if you are hospitalized.

Ambulatory surgical facilities, sometimes called out-patient or same-day surgery facilities, are equipped for many surgical operations such as:

- Cataract surgery
- Inguinal hernia repair
- Tonsillectomy and adenoidectomy
- Uncomplicated orthopedic procedures
- Dilation and curettage
- Cystoscopy

The Plan pays 100% of the eligible charges for expenses related to the use of the ambulatory surgical facility. Eligible charges include the same items covered as if you were hospitalized for the surgical procedure (See In-patient Hospital Benefits, page 16.)

By using an ambulatory surgical facility instead of staying overnight in a hospital, you begin your recovery that same night in the comfort of your own home, rather than in the unfamiliar surroundings of a hospital. Children especially enjoy this advantage, being at home among family and friends at a time when they need extra support and comfort. Furthermore, your family avoids the inconvenience of visiting the patient in the hospital. Since there is a financial incentive for any surgery to be performed on an ambulatory or out-patient basis, you should discuss the possibility of using one of these facilities with your doctor, whenever the need for surgery arises.

There are several types of ambulatory surgical facilities: free-standing or a part of an acute care hospital. Your Human Resources Representative can provide you with

confirmation that a particular hospital or free-standing ambulatory surgical facility is approved by the Claim Administrator.

Example of Ambulatory Surgery vs. In-patient Surgery

Your dependent needs a tumor removed from her wrist. Here's how the Plan would provide coverage if she has ambulatory (same-day) surgery versus being hospitalized.

Total Eligible Medical Services	TOTAL EXPENSES	
	Ambulatory Surgery	In-Patient Surgery
Hospital room & board	None	\$ 200
Hospital additional	None	300
In-patient doctor's visits	None	50
Surgeon's fee	\$750	750
Surgical Center Fee	<u>200</u>	<u>None</u>
Total Expenses	\$950	\$1,300
	Plan Pays	Plan Pays
	100%: \$950	90%: \$1,170
	You Pay	You Pay
	Nothing: <u>\$ 0</u>	10%: <u>\$ 130</u>

Voluntary Second Opinion

Second opinions are often wise to obtain when there is a difference in medical opinion, you are not responding to treatment, or when a diagnosis, treatment, or surgical procedure could radically change the course of your or an

eligible dependent's life. A second opinion may prevent unnecessary medical or surgical intervention, offer an alternative therapy and, of course, provide you with peace of mind. The Plan will pay the full reasonable and customary fee for a second medical or a voluntary surgical opinion. You may choose any doctor for the second opinion as long as the doctor is an appropriate board certified specialist.

Mandatory Second Surgical Opinion

Studies have shown there is a great deal of unnecessary elective or non-emergency surgery being performed. The second surgical opinion program is meant to lessen your chances of having unnecessary surgery and, of course, to reassure you that surgery is necessary.

The Health Care Plan will pay 100% of the reasonable and customary doctor's fee as well as for charges for tests necessary for you to receive a second opinion before undergoing **any** surgery.

If a doctor recommends one of the elective surgeries listed below, you **must** consult with another doctor (a board-certified specialist) prior to surgery to receive full medical benefits for all charges related to the surgery.

- Bunionectomy (removal of bunion)
- Cataract removal
- Cesarean section
- Cholecystectomy (removal of gall bladder)
- Coronary bypass
- Dilation and Curettage (D&C)

- Hemorrhoidectomy (not required for ligation technique)
- Herniorrhaphy (hernia repair)
- Hysterectomy (removal of uterus)
- Knee surgery (including excision of knee cartilage)
- Laminectomy (removal of part of vertebrae)
- Ligation and stripping of varicose veins
- Mastectomy and other breast surgery (not required for a breast biopsy)
- Prostatectomy (removal of part or all of the prostate gland)
- Submucous resection (repair of deviated septum)
- Tonsillectomy and/or Adenoidectomy

You may choose any doctor for the second opinion provided he/she is a board-certified specialist in treating your particular medical condition and is not financially or professionally associated with the first doctor who recommended the surgery. If the first and second opinions differ, the Plan also provides for full payment for expenses incurred if you seek a third surgical opinion from a board-certified specialist.

If you have the surgery for any one of the 16 required procedures and a second or third surgical opinion has been secured, regardless of the recommendation, the Plan pays full Plan benefits for charges related to the surgery (surgeon's fee, anesthesiologist's fee, pre-admission testing, hospital charges, etc.).

If you have the surgery without receiving a second surgical opinion, the Plan only pays 50% of all charges related

to the surgery (surgeon's fee, anesthesiologist's fee, pre-admission testing, hospital charges, etc.).

A second surgical opinion claim form must be completed prior to surgery by both doctors rendering surgical opinions. These forms are available in the Human Resources Department. The Plan does not cover doctor's charges for completion of the claim forms.

To avoid unnecessary duplicate testing, you should provide the second opinion doctor with any test results from the first doctor who recommended surgery.

The second surgical opinion requirement for these 16 procedures applies whether you have surgery while hospitalized or if you have surgery on an ambulatory (same day) basis.

If Medicare is your primary coverage, a mandatory second surgical opinion is not required to receive full FMC Health Plan benefits.

Example of Mandatory Second Surgical Opinion

Your spouse's doctor recommends that she have a hysterectomy. Here's how the Plan would provide coverage if your spouse received a second opinion prior to the surgery and if she had the surgery without getting a second opinion.

Total Eligible Medical Services	Total Expenses
Hospital room and board	\$1,400
Hospital additional	4,200
Surgeon's fee	1,500
Anesthesiologist's fee	500
In hospital doctor visits	400
	<u>\$8,000</u>
If second opinion secured:	
Plan pays 90%	\$7,200
You pay 10%	\$ 800
If no second opinion secured:	
Plan pays 50%	\$4,000
You pay 50%	<u>\$4,000</u>

Alcohol & Drug Abuse Rehabilitation Facility

If you or any eligible dependent require treatment for alcoholism or drug abuse, you can obtain effective treatment in a facility specializing in such care as an alternative to a full-service hospital. Treatment must be prescribed by a doctor. The alcohol or drug abuse facility must be licensed and approved by the Joint Commission on Accreditation of Hospitals. An effective treatment program includes individual therapy by a physician or group therapy, and an intention to enter into and remain in a comprehensive follow up program. The follow up program must include therapy at least once a month by a physician or group therapy under a physician's direction, plus attendance at least twice a month at meetings or

organizations devoted to the therapeutic treatment of alcoholism, chemical dependency, or drug addiction. Half-way houses or extended treatment centers are not covered.

Charges from an alcohol or drug abuse rehabilitation facility are covered at 100% up to the first 30 days of confinement. A second admission is covered at 50% for up to 30 days of confinement. A confinement may be less than 30 days, however, charges incurred in excess of 30 days for each confinement are not covered. There is a lifetime maximum of two covered confinements per person.

Example of Alcohol & Drug Abuse Rehabilitation Facility

Let's suppose you needed to be hospitalized for 30 days for treatment of alcoholism. Here's how the Plan would cover your expenses in a full-service hospital and in a specialized alcohol treatment facility:

Total Eligible Medical Services	Total Expenses
Room & Board	\$6,000
Doctor's visits	500
Additional	<u>2,000</u>
	<u>\$8,500</u>

Full-service Hospital:

Plan pays 90%	\$7,650
You pay 10%	\$ 850

Alcohol Treatment Facility:

Plan pays 100%	\$8,500
You pay nothing	<u>\$ 0</u>

Rehabilitation Facility

Rehabilitation facilities offer comprehensive, physical rehabilitation for victims of stroke, birth defects, accidents and other disabling conditions. Charges from an approved rehabilitation facility are covered at 100% up to the first 30 days of confinement. A second admission is covered at 50% for up to 30 days of confinement. A confinement may be less than 30 days. However, charges incurred in excess of 30 days for each confinement are not covered. There is a lifetime maximum of two covered confinements per person.

- Comprehensive treatment for chronic pain is covered under this provision. The coverage has a lifetime limit of 10 days and must meet the Claim Administrator's criteria and approval.

Hospice Care

A hospice is a facility that offers a coordinated program of home care and in-patient care for a terminally ill patient and the patient's family. The program provides supportive care to meet the special needs from physical,

psychological, spiritual, social and economic stresses which are often experienced during the final stages of terminal illness and during dying and bereavement.

The Plan covers hospice charges for terminally ill covered employees and for members of the patient's family who are covered as dependents under this Plan. A terminally ill patient is someone who has a life expectancy of approximately six months or less, as certified in writing by the doctor who is in charge of the patient's care and treatment. If you are in a hospice program, the Plan will pay 100% of covered charges for:

- In-patient health care
- Services of a physician
- Health care services at home – including part-time nursing care, use of medical equipment, rental of wheelchairs and hospital-type beds, and homemaker services
- Emotional support services, physical and chemical therapies
- Bereavement counseling sessions for family members

The maximum benefit payable for all hospice charges in connection with a terminally ill patient is \$5,000. When this limit is reached, payments for medical services will be made if they are covered under other parts of the Health Care Plan. These hospice benefits are in place of all other benefits provided under any other part of the Plan for the same services. During the 12 months following the death of the terminally ill patient, the Plan will pay up to \$25 for each bereavement counseling session for covered family members, up to a limit of 12 sessions.

Skilled Nursing Facility

A skilled nursing facility may be a skilled nursing home, or a distinct part of an institution, such as a ward or wing of a hospital, or a section of a facility another part of which is a geriatric center. An approved facility must be primarily engaged in providing skilled nursing care or rehabilitation services. At least one registered nurse must be employed full-time and adequate nursing service (which may include practical nurses) must be provided at all times. Every patient must be under the supervision of a doctor and a doctor must always be available for emergency care. The facility must be certified by the state. It also must have a written agreement with a hospital that is participating in the Federal Government's Medicare program for the transfer of patients. Not all nursing homes will qualify; those which offer only custodial care are excluded.

After a stay in the hospital, you may still need special medical care but to a lesser degree than a hospital provides. You can receive that care in an approved skilled nursing facility. Your physician must certify medical necessity for transfer from a hospital to an approved skilled nursing facility within 3 days of your hospital discharge date. The Plan pays 100% of the reasonable and customary charges for room and board and medical services for up to 30 days per person per calendar year. **The emphasis is on rehabilitation – helping you fully recuperate and return to a productive life. Charges from a skilled nursing facility will not be covered if the services received are personal or custodial care such as help with bathing, dressing or eating. If you are readmitted within 14 days of discharge from a skilled nursing facility**

and you have not exhausted the 30 day limit, it is considered the same confinement.

Home Health Care

Home health care means you can receive necessary medical care in your own home and avoid a long, costly hospital stay. The Plan provides 100% of reasonable and customary charges for up to 60 home health care visits per person per calendar year. **A visit is limited to two hours in any 24 hour period. Your attending physician must prescribe home health care and you must begin the program within 14 days after discharge from the hospital or from a skilled nursing facility. Home health care must be directly related to the condition for which hospitalization was required. Care is provided by licensed and Plan approved home health care agencies and includes such services as therapy, nursing care, medical social services, diagnostic services and other medical services to help you while you are confined to your home.** Benefits are not payable for custodial care such as the provision of meals, housekeeping or other non-medical assistance. Physician visits are covered under Health Maintenance benefits.

Birth Center

A birth center is a facility where healthy women can participate in prenatal screening and have their baby in a home-like atmosphere. Approved facilities are staffed by certified midwives, physicians and other trained personnel. Facilities consist of birthing rooms, living room, kitchen facilities and a family waiting room. Birthing

centers have the necessary medical equipment, backup physicians and written agreement to transfer to a hospital if necessary. Discharge is usually within 24 hours when mother and newborn are stable. The birth center offers a satisfying and enriching childbirth experience. The Plan covers 100% of the reasonable and customary charges from a Plan approved and licensed birth center.

Homebirths

An increasing number of expectant mothers are deciding to give birth at home, necessitating the provision of safe, homebirth services for those individuals who choose this alternative. For this reason, certain criteria must be fulfilled. The Plan covers 100% of the reasonable and customary charges from a Plan approved homebirth program.

Other Health Care Alternatives

If the need arises, you should discuss with your doctor the possibility of using one of these special health care alternatives to costly in-patient hospital care. You may save yourself time and money and receive more specialized care.

Pre-Admission Testing

Your Plan pays 100% of covered charges for pre-admission testing (i.e., x-rays and laboratory tests, etc.) incurred on an out-patient basis within 14 days prior to a hospital confinement. There is no deductible required for pre-admission testing. The charges must be related to the

sickness or injury that ultimately causes confinement. However, if you receive these tests while hospitalized, the Plan pays 90% of the charges and you pay the additional 10% of charges. Pre-admission testing that is repeated in the hospital will not be paid unless medically necessary as determined by the Claim Administrator.

Out-Patient Diagnostic X-ray & Laboratory Charges

Your Plan pays 100% of the first \$1,000 of eligible charges per calendar year for out-patient diagnostic x-ray and laboratory tests. Additional charges are covered at 90%, after the deductible is satisfied. Allergy tests are covered under this provision. Any diagnostic x-ray and laboratory tests performed while confined to the hospital are covered at 90%.

Charges Resulting from an Accidental Injury

Your Plan pays 100% of the first \$1,000 of eligible out-patient charges per accident that are incurred within 90 days of an accident. Charges over \$1,000 are covered at 90%, after the calendar year deductible is satisfied. Charges related to an accidental injury incurred after 90 days are also covered at 90%, after the calendar year deductible is satisfied. The accident must have occurred while you were covered by this Plan. Services provided by a chiropractor in an accident situation are specifically excluded under this provision of the Plan, but are included under the special chiropractic provisions of this Plan. (Please see page 34).

Some of the charges resulting from an accident may also be covered under other provisions of your Health Plan.

For example, if you are admitted to the hospital for treatment as a result of an accident, the Plan provides 90% of covered charges, no deductible (instead of 100% coverage). As such, there is a financial incentive to have accident-related treatment performed on an out-patient basis instead of an in-patient basis.

Out-Patient Emergency Illness

Out-patient emergency medical care benefits are **not** subject to deductible and are paid at 90%. This includes hospitals, physician services and emergency ambulance transport. Emergency illness is a sudden unexpected medical condition requiring immediate medical attention – such as loss of breath, severe chest pains, sudden blindness or other acute conditions with symptoms severe enough that the absence of medical attention could reasonably result in death or cause impairment to bodily functions of the patient.

A chronic condition in which symptoms have existed over a period of time would not qualify for medical emergency consideration. Medical care must be provided within 48 hours of onset of the illness.

Note: Charges for the use of the hospital emergency room for a non-life threatening medical condition are subject to the deductible and are payable at 50%. Exception: You are out-of-town and immediate access to a non-hospital based physician is not timely.

HEALTH MAINTENANCE BENEFITS

90% Coverage – Deductible Required

Your Health Maintenance Benefits are designed to help pay expenses for certain services and supplies not covered under other parts of the Plan. All Health Maintenance services must be necessary to treat illness or injury and the provider of services must meet the Plan's definition of a doctor defined on page 13.

The Deductible

You are responsible for the first \$150 in a calendar year of any charges covered under this part of the Plan. This \$150 amount is called the deductible. It applies to each covered person once each calendar year. Once the deductible for the calendar year has been met, the Plan pays 90% (85% for out-patient psychiatric) of all the remaining covered expenses for the rest of that calendar year.

Once two or more eligible members of your family have applied \$300 towards the Plan deductible in the same calendar year, no additional deductible will be required for your family during that calendar year. No person can apply more than \$150 of covered expenses toward the family limit of \$300.

Example of Individual Deductible

Let's assume one individual incurs the following expenses.

Eligible Expenses	\$ 280
minus	
Individual Deductible	- 150
Expenses After Deductible	\$ 130
times	
Benefit Payment Percentage	x90%
Benefit Pays	<u>\$ 117</u>

Example of Family Deductible

The chart below shows how a family's expenses are applied to the family deductible.

Family Member	Expenses Eligible for Benefit	Expenses Applied to \$300 Family Deductible
1	\$ 75	\$ 75
2	750	150
3	100	75
4	100	-
5	+ 75	+ -
	<u>\$1,100</u>	<u>\$300</u>

The plan would then pay these benefits:

Eligible Expenses	\$1,100
minus	
Family Deductible	- 300
Expenses After Deductible	\$ 800
times	
Benefit Payment Percentage	x 90%
Benefit Pays	<u>\$ 720</u>
SUMMARY	
Total Charges:	\$1,100
Benefit Pays:	<u>- 720</u>
You Pay:	<u>\$ 380</u>

Expenses that are considered Health Maintenance Benefits payable at 90% of the reasonable and customary amount, after the deductible is satisfied, include:

Cardio-Vascular Exercise Regimen

• A cardio-vascular exercise regimen is a course of medically supervised exercise therapy to improve efficiency of the heart, lungs, and circulatory system. The treatment facility must be an approved center, hospital, or rehabilitation hospital. The provider of care must be a board-certified cardiologist. The program must use telemetry, monitoring and be equipped with appropriate emergency equipment. A person is eligible for this benefit only if the regimen is prescribed by a doctor under these conditions:

- Stable angina pectoris (chest pain)
- High risk coronary artery disease -
- Following a heart attack
- Following heart bypass surgery
- Individuals with clinical symptoms of heart disease

- Coverage includes:

- Initial physical examination, history and physical performed by a cardiologist
- X-ray and laboratory tests
- Exercise visits

There is a \$1,000 lifetime maximum per person for all charges related to a cardio-vascular exercise regimen, including x-ray and laboratory tests.

Other Covered Charges

- Newborn childcare – Newborns require routine medical care, especially during the early years following birth. Our Plan covers up to five office visits for routine check-ups – including doctor's fee, lab tests and immunizations – during the baby's first 12 months and Two routine check-ups during the baby's second year.
- Immunizations – to prevent illness.
- Dietary instruction for diabetes – when prescribed by a doctor.
- Prescription Drugs – obtainable only by a doctor's prescription and filled by a pharmacist for treatment of an illness or injury. See definition of prescription drug on page 13.
- Biofeedback – up to a maximum of 25 treatments per calendar year. If the treatment is in connection with a mental or nervous condition, the Plan's psychiatric limitations and maximum apply. (See page 35.)
- Acupuncture – 8 initial treatments; no treatment for 30 days; then 6 additional treatments over a 9-month period.
- Out-patient doctor visits – when required as a result of illness or injury. Routine doctor's visits are not covered, except for newborn childcare benefits as described on page 32.

- Physical therapy – when prescribed by a doctor for reasonable & customary treatment of disease, bodily injury, or defects. (See Optional Pre-Treatment Benefit Review, page 15.)

- Up to a maximum of 35 treatments per calendar year
- Restoration of treatment if surgery occurs, or for an unrelated condition

- Speech therapy – when prescribed by a doctor for treatment of a condition that arises from a non-occupational injury or illness. The patient must have the capacity to verbally communicate at the time therapy is begun. Speech therapy for education or training is not covered.

- Pain therapy – when prescribed by a doctor for the evaluation and treatment of **chronic** pain due to a non-occupational injury or illness.

The program should help the patient develop pain management techniques that will help lead as normal a life as possible. After initial evaluation, a written plan of therapy must be submitted to the Claim Administrator. Examples of chronic pain therapy centers include: Spinal cord injury pain; Low back pain; and Cancer pain centers. The pain clinic or center must fulfill the criteria of the Claim Administrator. Coverage is limited to two lifetime one-to-four week outpatient pain therapy programs.

(Some pain therapy treatments are covered under other provisions of the Plan, i.e., acupuncture, and biofeedback).

- Chiropractic care – benefits will be provided for chiropractic care and consist of spinal adjustments of subluxations which may cause acute and chronic conditions. Common measures of case management and procedures to monitor the patient's progress must be outlined and

submitted to the Claim Administrator. Chiropractors must practice within the limits of licensure and includes:

- Case History
- Physical findings (subjective and objective)
- Spinal Examination
 - Visual
 - Digital
- X-rays
- Other pertinent chiropractic procedures

It does not include:

- Maintenance care
- Preventative examinations
- Treatment for mental/nervous disorders
- There is a \$500 calendar year maximum. Claims may be reviewed by a Chiropractic Claim Review Committee at the discretion of the Claims Administrator.
- Local ambulance service
- Oxygen and blood
- Private duty nursing (RN or LPN)
- Chemotherapy and radiation therapy
- Prescribed, durable medical equipment and appliances (such as hospital beds, respirators and wheel-chairs) primarily used in treatment and generally not useful in the absence of illness or injury. Equipment or appliances for convenience, accommodation or household use are not considered durable medical equipment. A written prescription from a doctor is required and the Claim Administrator determines whether or not the appliance or equipment is covered under the Plan. If less expensive, the equipment should be purchased rather than rented. If

rented, the total rental fees cannot exceed the purchase price. If the price of the purchased item is \$500 or greater, the purchase must be approved in advance by the Claim Administrator.

Out-Patient Psychiatric Care – Covered at 85%

Out-patient psychiatric charges are payable at 85% (after the deductible requirement) and are subject to a \$15,000 lifetime maximum benefit per person. Psychiatric day care, an alternative to hospitalization, is also covered under this section.

The eligible expenses for out-patient psychiatric care is limited to the fees of:

- a psychiatrist (M.D.)
- a psychologist who is a member of the American Psychiatric Association and is licensed by the state in which he or she practices.

Services must be provided as an individualized treatment plan on the basis of evaluation of the patient's restorative potential and the treatment must be reasonably expected to improve the patient's condition. Individual or group therapy which is rendered by either a psychiatrist or psychologist is limited to one session per week but not to exceed the \$15,000 lifetime maximum.

The disorder being treated must be included in the mental or nervous conditions defined by the American Psychiatric Association. Charges for out-patient treatment for alcohol and drug abuse are covered under this provision. This benefit does not cover educational testing, learning disabilities, mental retardation or marriage and family counseling. Charges from a Licensed Marriage, Family

and Child Counselor are not covered. If you have questions about specific coverage you should request a pre-treatment review from the Claim Administrator.

There is no reinstatement of the \$15,000 lifetime maximum. All claims are subject to a progress review at the discretion of the Claims Administrator.

MEDICAL CASE MANAGEMENT

Medical Case Management is a program to assure quality health care while controlling high health care costs connected with a severe personal injury or sickness. "Severe personal injury or sickness" means any of the following which result in the person becoming totally disabled:

- major head trauma
- spinal cord injury
- amputations
- multiple fractures
- severe burns
- neonatal high risk infants
- severe stroke
- multiple sclerosis
- amyotrophic lateral sclerosis
- end stage cancer
- acquired immune deficiency syndrome (AIDS)

The objectives of this program are to find and cover care conscious and cost conscious medical alternatives. Medical alternatives means services and supplies which:

- may not be covered under other parts of the plan;
- can be used in place of other services and supplies that are covered elsewhere; and
- are more appropriate in the long term care of the patient.

The flexibility of this program allows all options of care to be explored and considered for coverage based on the uniqueness of each case. The program will begin when a person covered for medical benefits suffers a severe personal injury or sickness based on an objective review.

Benefits under this program will be paid in accord with the following provisions:

- Benefits will be paid for reasonable and customary charges for services and supplies furnished to the patient.
- Benefits will be paid to the extent that they are in excess of the total benefits payable for such charges under all other parts of the plan.
- The injury or sickness must happen and all charges must be incurred while the patient is covered under the plan.
- The amount of the benefit payment for these charges will be determined by the Plan Administrator.
- The maximum benefit is subject to the overall lifetime maximum under the Plan.

CATASTROPHIC PROVISION

\$1 Million Dollar Maximum

If you or an eligible member of your family face a serious illness or injury, your Health Care Plan helps prevent you from suffering severe financial hardship due to catastrophic medical expenses.

The plan provides a \$1 million dollar lifetime maximum benefit per person.

Additionally, if you or an eligible member of your family pay more than \$1,500 in eligible medical expenses under this Plan (including the deductible) during a calendar year, the Plan pays 100% of all additional eligible charges that are normally paid at 90% for that person during the rest of that calendar year. This is called the "out-of-pocket expense limit". There is a similar limit for your family's out-of-pocket expenses. If out-of-pocket costs for you and your family under this Plan reach \$3,000 in a calendar year, the Plan pays 100% of the remaining eligible expenses that are normally paid at 90% for the rest of that calendar year. In other words, regardless of how high your eligible medical expenses are in a calendar year, you will not pay more than \$1,500 for your eligible expenses or \$3,000 for your entire family's eligible expenses that are normally paid at 90%.

There is one exception to this catastrophe coverage – in-patient and out-patient psychiatric charges do not apply to the out-of-pocket maximum; however, they do count toward reaching the \$1 million maximum.

Example of Catastrophic Coverage

If you became seriously ill and were hospitalized, the Plan would provide coverage in the following way:

<hr/> Total Eligible Medical Services <hr/>	Total Expenses
Ambulance	\$ 50
Hospital room and board	1,800
Hospital additional	12,000
Surgeon's fee	4,000
Anesthesiologist's fee	1,000
In-hospital doctor visits	350
	<hr/> <u>\$19,200</u>
• Plan pays 90% of first \$15,000	\$13,500
• You pay 10% of first \$15,000	\$ 1,500
• Plan pays 100% of remaining expenses	\$ 4,200
SUMMARY	
Total Charges:	\$19,200
Plan pays:	\$17,700
You pay:	<u>\$ 1,500</u>

Your individual out-of-pocket maximum of \$1,500 was met. For the rest of the calendar year, the Plan will cover 100% for most additional eligible expenses for you.

EXPENSES NOT COVERED

The Plan's purpose is to help pay expenses which are for prescribed and necessary treatment of illnesses or injuries within the reasonable and customary limits. Some expenses, even if prescribed, are not covered. The Plan does not cover:

- Charges in excess of reasonable and customary charges. (See page 12 for a definition of reasonable and customary.)
- Charges which are not eligible charges (See page 13 for a definition of eligible charge).
- Charges for medical treatment (including hospitalization) not necessary for medical care, is not an acceptable medical practice, or for medical treatment which is experimental. The determination of necessary or experimental will be made by the Claim Administrator and your physician's opinion does not make the medical care necessary, or in the case of experimental treatment, your physician's opinion does not define the scope of treatment.
- Charges which exceed any of the Plan's maximums.
- Expenses incurred as a result of a work-related injury or illness, regardless of coverage under workers' compensation or other employer liability laws. This includes self-employment.
- Charges which you are not legally required to pay, or are provided by law, or which would not have been made if you were not covered by this Plan.
- Treatments prohibited by law or non-FDA approved drugs.
- A service or supply not ordered by a doctor.
- Expenses connected with cosmetic surgery unless due to an accident while covered, or for correction of congenital anomaly for children born while the mother is covered under the Plan.

- Charges for eye refractions (including surgery), vision training, eye glasses, corrective contact lenses or any procedures that correct a refractive error, or hearing aids or for examinations to determine the need for or adjustment of eyeglasses or hearing aids. This exclusion also includes expenses connected with radial keratotomy.
- Charges for treatment on or to the teeth, gums or surrounding tissues other than those specific procedures described under "Surgery" on page 18.
- Charges for any treatment of appliances for TMJ (temporomandibular joint syndrome) including surgery and/or hospitalization.
- Charges for routine or annual medical checkups except for diagnostic X-ray and laboratory charges as explained on page 28 and newborn care as explained on page 32.
- Expenses connected with treatment of weak, strained or flat feet or instability or imbalance of the feet, metatarsalgia or bunions, except open cutting operations.
- Doctors' services for treatment of superficial lesions of the feet including corns, calluses and hyperkeratoses.
- Services, supplies, testing and other charges related to In-Vitro Fertilization.
- Charges for educational testing, training, and assessments for mental capacity.
- Charges in connection with speech therapy for education or training. (See page 33.)
- Charges by a veterans, military, public health service or other federal health care facility, or paid by a government agency. Also, charges by a charitable hospital or organization are specifically excluded.
- Charges incurred for accommodations (including room and board and other institutional services) and nursing services primarily to assist the person in daily living activities. These charges will be considered custodial care

and are not payable. This limitation also applies to individuals receiving medical service that is merely maintenance care that cannot reasonably be expected to substantially improve a medical condition.

- Charges for medical care or supplies incurred as a result of injury if you or your dependent engage in an illegal action, or are the aggressor in a dispute.
- Charges for dietary instruction unless prescribed for diabetes.
- Charges incurred for services rendered by a provider who does not meet the Plan's definition of a doctor or provider of services as described on page 13.
- Charges for non-medical services and equipment – even if prescribed – such as athletic or health club dues, environmental control equipment, air conditioners, air purifiers, humidifiers, exercycles, treadmills, waterbeds, bathroom safety equipment, etc. (See page 34.)
- Charges for personal expenses during hospitalization such as hospital comfort kits, hospital admission kit, telephone, television, etc.
- Charges incurred prior to the effective date or after the termination date of this coverage.
- Acupuncture when performed by anyone other than a doctor.
- Treatment given at a medical facility maintained by FMC, or provided through any other Plan paid for or sponsored by the company.
- Treatment given by a member of your immediate family or your spouse's immediate family, i.e, parent, sister, brother.
- Any sales or other taxes, or any service or interest charges.
- Charges for the completion of claim forms or preparation of medical reports.

- Charges for vocational evaluations.
- Services or supplies that are not described in this booklet.

CLAIMING BENEFITS

Evidence of Coverage

You will receive an identification card on the effective date of your medical coverage. The card identifies you as a member of this Plan. When you are admitted to a hospital, present this card as evidence of your coverage.

Making a Claim

Often you'll know in advance when you, or a covered family member requires hospitalization. Before going in, it's a good idea to talk with the Human Resources Department about how claims are processed under our Plan. They will provide you with forms for filing your claim.

In general, to file a claim you must complete the original form and return it to your Human Resources Department, or to your direct claims administration office, along with your itemized bills.

The employee's social security number must be on the original claim form. If the number does not appear, the Claim Administrator will not process the claim.

You must also be able to provide proof of all expenses – including those that apply to the deductible. Be sure to keep all bills and receipts, and make certain they are itemized and contain the following information:

- your name (or the name of the patient if not you)

- the name, address and telephone number of the provider
- the nature of the illness – diagnosis must be shown
- the type of service performed
- the date the service was provided
- the amount charged

The Claim Administrator requires original bills and receipts. They will pay your claims as soon as they are satisfied that your expenses are covered by the Plan and your proof is valid.

Certain benefit provisions have limits and lifetime maximums. As a consumer, you should keep a record of paid benefits. The Claim Administrator, upon request, can furnish you with an up-to-date benefit status. It is not the responsibility of either the Claim Administrator or FMC to notify you of impending benefits that will exceed Plan limits or maximums. If you do not submit a claim within one year of the date the expenses were incurred, there will be no coverage for that particular expense.

Claims are subject to routine auditing for fraud, duplicate coverage and subrogation.

COORDINATION OF BENEFITS

If you or a covered member of your family are eligible to receive benefits under another group medical plan, Health Maintenance Organization (HMO), government plan, or by "no-fault" automobile insurance which provides medical coverage, you may be eligible for benefits from those Plans and your FMC Plan. In the case of

coverage by "no-fault" automobile insurance, FMC will pay covered expenses not paid for by no-fault insurance.

The benefits paid from this Plan will be coordinated to cover up to – but no more than – 100% of the benefits allowable under this Plan.

One Plan pays first. This is determined as follows:

- The Plan with no coordination of benefits provision pays before a Plan that has a coordination provision.
- The Plan covering the person as an employee pays first.
- In situations of divorce, separation, and/or divorce and remarriage, benefits for a child's medical expenses will be payable as follows:

1. If a court decree has established financial responsibility for medical expenses for the child, the Plan of the parent with such financial responsibility pays first, the Plan of the other natural parent pays second, and the Plan covering the spouse of the parent with financial responsibility (the step-parent) pays third.

2. If there is no court decree which establishes financial responsibility for the child's medical expenses, the Plan of the parent who has custody of the child pays first, the Plan covering the spouse of the parent who has custody (the step-parent) pays second, and the Plan of the natural parent without custody pays third.

- For children's expenses, the Plan of the parent having the earlier birthday in the calendar year pays first. For example: if the father's birthday is July 2 and the mother's birthday is March 27, the mother's plan is primary for the couple's dependent children. If the father's and mother's birthdays are on the same day, the plan covering a parent longer is the primary plan.

- The Plan that covers the claimant as an active employee pays before a Plan covering the claimant as a retired or laid-off employee.

Usually, by this time a priority for paying has been established, but if it has not:

- The Plan that has covered the claimant for the longest time pays first.

The plan paying first, called the primary plan, pays up to its maximum benefits. The other plan or plans pay as many of the unpaid charges as are allowed, according to each plan's provisions. If the expense is subject to a deductible, both plan's deductibles must be met before benefits are payable.

You will never receive less if you are covered under two or more medical Plans than you would if you were covered by this Plan alone. However, the most your FMC Health Care Plan will pay is an amount that would bring benefits to FMC levels. For example, if your spouse is covered by another plan and that plan pays an amount equal to or greater than the FMC Plan, FMC would make no additional payment. (See pages 46-48 for examples of how Coordination of Benefits works.)

To avoid lengthy delays in processing your claim, it is important that you file it properly when Coordination of Benefits applies. If your spouse or eligible family member is covered under another employer's plan so that FMC has secondary responsibility as described above, submit the application to the other employer first. Then, submit your application to FMC in the normal manner with a copy of the payment statement from the other plan so that the extent of FMC's secondary responsibility can be determined. If the Claim Administrator for the FMC Plan pays more than it should when another Plan is involved,

it will request a repayment of benefits from the other plan or from you.

EXAMPLES OF COORDINATION OF BENEFITS

ABC Company Has Lower Benefit Level Than FMC

Let's assume your spouse, who is employed by ABC Company, incurs eligible out-patient doctor's charges of \$750. In this case, ABC Company, your spouse's employer, is "primary" and the FMC Plan is "secondary".

Let's suppose the ABC Company's Plan (primary payor) pays for 80% of the eligible expenses (after the deductible) and the FMC Plan (secondary payor) pays 90% of eligible expenses (after the deductible).

Here's how your Coordination of Benefits provision works.

Step 1	ABC Company	FMC Corporation
Total eligible expenses	\$ 750	\$ 750
Subtract the deductible	-150	-150
	<u>\$ 600</u>	<u>\$ 600</u>
Rate of benefit payment	x 80%	x 90%
Primary payor pays	<u>\$ 480</u>	<u>\$ 540*</u>

(*FMC would pay this amount if it were the primary payor.)

STEP 2

From the expenses that FMC would normally cover - \$ 540
 FMC subtracts what ABC Company (primary payor) pays - -480
 And FMC pays the difference \$ 60

Therefore, your spouse would receive a total of \$540 - \$480 comes from ABC Company, the primary payor and \$60 comes from FMC. You and your spouse would be financially responsible for paying out-of-pocket the \$210 balance due (\$750 less \$540) to the physician.

ABC Company Has Higher Benefit Level Than FMC

Let's assume your spouse, who is employed by ABC Company, incurs eligible out-patient doctor's charges of \$750. In this case, ABC Company, your spouse's employer, is "primary" and the FMC Plan is "secondary".

Let's suppose the ABC Company's Plan (primary payor) pays for 95% of the eligible expenses (after the deductible) and the FMC Plan (secondary payor) pays 90% of eligible expenses (after the deductible).

Here's how your Coordination of Benefits provision works.

	ABC Company	FMC Corporation
Total eligible expenses	\$ 750	\$ 750
Subtract the deductible	-150	-150
	<u>\$ 600</u>	<u>\$ 600</u>
Rate of benefit payment	x 95%	x 90%
Primary payor pays	<u>\$ 570</u>	<u>\$ 540*</u>

(*FMC would pay this amount if it were the primary payor.)

In this example, your spouse would receive a total of \$570 from ABC Company. Since ABC Company pays a higher benefit than the FMC Health Care Plan, FMC will make no additional payment.

ABC Company Has Same Benefit Level As FMC

Let's assume your spouse, who is employed by ABC Company, incurs eligible out-patient doctor's charges of \$750. In this case, ABC Company, your spouse's employer, is "primary" and the FMC Plan is "secondary".

Let's suppose the ABC Company's Plan (primary payor) pays for 90% of the eligible expenses (after the deductible) and the FMC Plan (secondary payor) pays 90% of eligible expenses (after the deductible).

Here's how your Coordination of Benefits provision works.

	ABC Company	FMC Corporation
Total eligible expenses	\$ 750	\$ 750
Subtract the deductible	-150	-150
	<u>\$ 600</u>	<u>\$ 600</u>
Rate of benefit payment	x 90%	x 90%
Primary payor pays	<u>\$ 540</u>	<u>\$ 540*</u>

(*FMC would pay this amount if it were the primary payor.)

In this example, your spouse would receive a total of \$540 from ABC Company. Since ABC Company pays the same benefit as the FMC Health Care Plan, FMC will make no additional payment. You and your spouse would be financially responsible for paying out-of-pocket the \$210 balance due (\$750 less \$540) to the physician.

No-Fault

In some states with no-fault motor vehicle coverage, the carrier is the primary insurer in these jurisdictions. All medical expenses related to an accident must be submitted to the carrier and not the FMC Health Care Plan. Eligible expenses not paid for by no-fault insurance will be paid by the FMC Plan.

Third Party Reimbursement

If you or an eligible family member incur medical or dental expenses for an illness or injury because of the fault of another person, that person is responsible for any

hospital or medical expenses which may result. Collecting this money may take several months. In such cases, your FMC Health Plan will pay the appropriate benefits. However, the FMC Plan has the right to seek repayment of those benefits from the party that causes the illness or injury. Automobile accident injuries or personal injury suffered on another's property are examples of cases subject to this provision.

The FMC self insured benefit program is automatically assigned the right of action against third parties in any situation in which benefits are paid to employees or their dependents. If you bring a liability claim against any third party, benefits payable under this Plan must be included in the claim, and when the claim is settled you must reimburse the Plan for the benefits provided. You are obligated to avoid doing anything which would prejudice the Plan's rights of reimbursement, and you are required to sign and deliver documents to evidence or secure those rights. Unless you sign the Company's "third party reimbursement form," the Claims Administrator will not process any claim where there is possible liability on behalf of a third party.

Medicare Coverage if You Are Totally Disabled

If you or any eligible family member meets the disability eligibility requirements for Medicare, the FMC Health Care Plan benefits will be reduced by the amount Medicare pays, or would have paid if Medicare coverage had been in effect.

Medicare benefits are generally available to someone who has been receiving Social Security disability benefits for two consecutive years.

If you or any eligible family member becomes eligible for Medicare, you must apply for both Parts A and B. Your Human Resources Representative or your local Social Security office can help you complete the application. **If you do not apply when you are eligible, your FMC Health benefits will be reduced as though you had Medicare coverage.**

When the FMC Health Plan is reduced by Medicare, the Coordination of Benefits rules are not applied unless there is coverage by another group health plan.

Quality Care Review

The Health Plan is designed to provide you and your family with quality medically necessary care. A quality care review system helps assure that the Plan meets this goal without paying unreasonable or unnecessary expenses.

In the unusual event that a question arises regarding the medical necessity of any treatment, professional medical evaluators – including physicians and specialists – may be asked to study the situation. After careful review, if they determine that the treatment was unnecessary, or outside the bounds of generally accepted medical practices in the United States, it may not be covered.

Alternative Treatment May Be Considered

Medical claims may be reviewed to assess the cost-effectiveness of ongoing treatments, services and supplies. This is done to assure that the Plan covers the reasonable expenses which are medically necessary to provide quality care. Although it's uncommon, it may be determined that a treatment, service or supply is available on a more cost-effective basis. This might include such things as the use of home nursing visits in place of a prolonged recuperation in a hospital or other facility, or the purchase or rental of equipment which is often available only in a hospital. In cases such as these, the Plan may cover only the less costly alternative.

HOW LONG COVERAGE CONTINUES

In This Situation:	This Happens to Your Coverage:
You are on disability leave of absence.	Coverage continues for you and your dependents for the length of your leave, provided you continue to pay your regular contributions.
You are on military leave of absence (excluding summer training).	Coverage ends for you and your dependents on the date you terminate. Coverage can be continued for you and your dependents. See the section, "Continuation of Coverage."

In This Situation:	This Happens to Your Coverage:
You are on a personal or education leave of absence.	Coverage may continue for you and your dependents for the length of your leave, provided you pay the entire cost. Please see the section, "Continuation of Coverage."
You terminate employment prior to retirement or transfer to an employee group the plan does not cover.	Coverage ends for you and your dependents on the date you terminate. If you desire continued health insurance protection after your coverage ceases, see the section, "Continuation of Coverage."
You retire from the Company.	Coverage ends for you and your dependents on the date you terminate. Coverage can be continued for you and your dependents if you so elect. See the section "Medical Coverage After Retirement."
A dependent becomes ineligible.	Coverage ends on the date the dependent becomes ineligible. If a dependent full-time student becomes ineligible due to the age 23 limitation, coverage continues until the end of the academic semester in which the student attained age 23. Coverage can

In This Situation:	This Happens to Your Coverage:
	be continued for your dependent. See the section, "Continuation of Coverage."
You die.	Continued coverage for dependents is based upon the deceased employee's age and service at time of death. There is no permanent coverage available for dependents unless the deceased employee was age 40 or older <i>and</i> had 10 or more years of credited service. The following outlines coverage continuation for dependents: Age 55 or Older With 10 or More Years of Credited Service - Coverage continues on the same basis as if the deceased had been a retiree. (See section headed, "Medical Coverage After Retirement".) Age 40 to 54 with 10 or More Years of Credited Service - Coverage can be continued for your dependents (See the section, "Continuation of Coverage"). Coverage under the FMC Retiree Health Care Plan is not available until the first of the month following the deceased employee's fifty-fifth birthday. At that time,

In This Situation:	This Happens to Your Coverage:
You die. (cont'd)	<p>coverage for eligible dependents continues on the same basis as if the deceased had been a retiree. (See section headed, "Medical Coverage After Retirement" for explanation of retiree coverage.)</p> <p>All Others - Coverage can be continued for your dependents (see the section, "Continuation of Coverage").</p> <p>For those dependents covered under the Retiree Health Care Plan, coverage ceases upon the spouse's death. Coverage for dependent children continues until the spouse dies or the children no longer qualify as dependents, whichever is earlier.</p>
The plan is terminated or changed so that it no longer covers your employee group.	Coverage for you and your dependents ends immediately.

Continuation of Coverage

If you or your eligible dependents lose coverage under the FMC Health Care Plan, health care coverage can be continued for you and your eligible dependents under

certain circumstances, provided you pay the full premium for this coverage.

Coverage for you and your dependents may be continued for up to 18 MONTHS if you:

1. Terminated or were terminated for reasons other than gross misconduct;
2. became ineligible for coverage because you experienced a reduction in hours worked.

Coverage for your eligible dependents may be continued for up to 36 MONTHS under the following circumstances:

1. If you become divorced or legally separated from your spouse;
2. if you die;
3. if you have dependent children who are covered under the Plan and who reach the Plan's limiting age (age 19, or age 23 for a full-time student);
4. your spouse and your dependents who are ineligible for Medicare if you should elect Medicare coverage and decline FMC's Health Care Plan.

Should you voluntarily terminate, are terminated, experience a reduction in hours or elect Medicare coverage instead of FMC's Health Care Plan, FMC will notify you within 14 days of the event as to the terms and duration of coverage. At the end of this notification period, the 60 day election period commences. During this time period, you can decide whether or not you wish to elect to continue FMC's Health Care Plan. In any event, you must make a decision by the end of this 60 day period. Should you decide to elect continued coverage under the FMC plan, you will have another 45 days in which to pay the appropriate premiums for the coverage. Your premiums are payable on a monthly basis.

Should you become either divorced or legally separated, or have an eligible dependent that reaches the age limit specified in the Plan, you must notify FMC in writing within 60 days after any of the said events take place. FMC will then provide information within the same time frame as indicated above.

If you do not notify FMC of status changes within the 60 day period, or if you do not pay your premiums when they are due, you will forfeit your continued coverage under the FMC Health Care Plan. There will be no exceptions to the 60 day notification period.

Your continued coverage under the FMC Health Care Plan will also end when the first of these events occur:

1. The FMC Health Care Plan terminates;
2. the end of the period allowed for continuation coverage;
3. the date you or your dependent become insured under another group health plan;
4. the date you or your dependents become eligible for Medicare.

Medical Coverage After Retirement

When you retire you can elect to participate in the FMC Health Care Plan for retirees. This Plan provides the same health care benefits you had as an active employee (described in the subsequent pages of this section of your handbook).

When you, your spouse or eligible dependent attain age 65, benefits will be coordinated with Medicare coverage; thus you are required to enroll and pay the required

premiums for Medicare Part "B". The FMC Health Care Plan begins paying benefits after Medical Parts A and B have paid the maximum benefit allowed. Thus, if you are not enrolled in Medicare Parts A and B, you are responsible to pay the charges that Medicare would normally cover.

You are required to pay monthly contributions for your health coverage. From time to time, depending upon Plan experience, the premium will be adjusted (usually upward). You will be notified, in advance, of any premium increase or decrease. Your Human Resources Representative can provide you with the current contribution rates.

Several items of importance concerning health care coverage for retirees include:

1. If you do not enroll yourself or any other eligible dependents in the FMC Retiree Health Plan when first eligible (following last day of active work), you permanently forfeit the right to enter the Plan.
2. If you enroll in the FMC Retiree Health Care Plan at retirement, but later drop out, you permanently forfeit the right to re-enter the Plan.
3. If you enroll in the FMC Retiree Health Care Plan at retirement and later marry, your new spouse is eligible for Plan coverage as long as enrollment is within 31 days of the marriage. Dependents of the new spouse are not eligible for coverage.
4. If you reside in a foreign country and have attained age 65, your benefits under this Plan will be calculated as if you were eligible and receiving both Medicare Parts "A" and "B". In no case, if you are age 65 or older, will the FMC Health Care Plan provide coverage without coordination for Medicare A and B regardless of eligibility.

Claim Fraud

The FMC Health Plan is intended to provide eligible benefits to eligible participants. Intentional false, incomplete or misleading information on enrollment cards and claim submissions are subject to disciplinary action. In addition, the company may terminate your employment and legally recover monies obtained fraudulently.

SITUATIONS THAT COULD AFFECT PLAN BENEFITS

1. FMC expects and intends to continue the Health Care Plan indefinitely. However, the Company reserves the right to amend or terminate the Plan at any time and for any reason. If the Plan is amended or terminated, you and other active and retired employees may not receive benefits as described in other sections of this booklet. You may be entitled to receive different benefits, or benefits under different conditions. However, it is possible that you will lose all benefit coverage. This may happen at any time, even after you retire, if the Company decides to terminate the Plan or your coverage under the Plan. In no event will you become entitled to any vested rights under this Plan.

2. If you do not apply for benefits or provide the necessary claim information, no benefits can be paid.

3. If you do not make required contributions when they are due, Plan membership will end. At that time, you will be permanently barred from re-entering the Plan; however, you will be eligible to continue coverage for you and you dependents as described in the "Continuation of Coverage" section.

OTHER INFORMATION ABOUT THE PLAN

1. FMC Corporation and the Claim Administrator keep all Plan records on a Plan-year basis, starting January 1 and ending December 31.

2. Claim denial appeal provisions are discussed in detail under the section titled "Additional Information" in this handbook.

3. The health care plan is funded through a contract with the Claim Administrator, Equicor.

4. The benefits outlined in this Summary Plan Description cannot possibly be conclusive due to space limitations. As a result, the Claim Administrator may invoke special limitations on eligible expenses, subject to generally accepted insurance industry practices.

5. This Plan is filed with the U.S. Department of Labor under Plan Number PN 540 and the Plan name FMC Salaried Health Plan.

EXHIBIT B

CYNTHIA ANN HOLLIDAY,	*	IN THE COURT OF
A MINOR, BY GERALD S.	*	COMMON PLEAS
HOLLIDAY, HER GUARDIAN,	*	INDIANA COUNTY,
Plaintiff	*	PENNSYLVANIA
	*	
VS.	*	CIVIL ACTION
	*	IN LAW
	*	
ROBERT SCOTT LYONS,	*	NO. 535
Defendant	*	C.D. 1987
	*	
	*	JURY TRIAL
	*	DEMANDED

(Filed April 21, 1987)

NOTICE

You have been sued in Court. If you wish to defend against the claims set forth in the following pages, you must take action within twenty (20) days after this complaint and notice are served, by entering a written appearance personally or by attorney and filing in writing with the Court your defenses or objections to the claims set forth against you. You are warned that if you fail to do so the case may proceed without you and a judgment may be entered against you by the Court without further notice for any money claimed in the complaint or for any claim or relief requested by the Plaintiff. You may lose money or property or other rights important to you.

YOU SHOULD TAKE THIS PAPER TO YOUR LAWYER AT ONCE. IF YOU DO NOT HAVE OR KNOW A LAWYER, THEN YOU SHOULD GO TO OR TELEPHONE THE OFFICE SET FORTH BELOW TO FIND OUT WHERE YOU CAN GET LEGAL HELP:

Count Administrator
4th Floor, Courthouse
Indiana, PA 15701
(412) 465-2663

CYNTHIA ANN HOLLIDAY, A MINOR, BY GERALD S. HOLLIDAY, HER GUARDIAN,	* IN THE COURT OF * COMMON PLEAS * INDIANA COUNTY, * PENNSYLVANIA
Plaintiff	* CIVIL ACTION
VS.	* IN LAW
ROBERT SCOTT LYONS,	* NO. _____
Defendant	* C.D. 1987
	* JURY TRIAL * DEMANDED

COMPLAINT

1. The Plaintiff, Cynthia Ann Holliday is a minor, having been born on September 13, 1971, and resides in Indiana County at 1569 Church Street, Indiana, Pennsylvania 15701.

2. Gerald S. Holliday is an adult individual who is the natural father and guardian of Cynthia Ann Holliday and who resides in Indiana County at 1569 Church Street, Indiana, Pennsylvania 15701.

3. The Defendant, Robert Scott Lyons, is a minor, having been born on February 16, 1970, and resides in Indiana County at 941 McHenry Road, Indiana, Pennsylvania 15701.

4. The facts and occurrences hereinafter stated took place on January 16, 1987, at or about 2315 hours in White Township, Indiana County, Pennsylvania on Ben Franklin Road.

5. At the aforesaid time and place, Plaintiff was lawfully riding as a passenger in a 1977 Mercury Marquis, vehicle Title number 29791530, being operated by Robert Scott Lyons, Defendant.

6. At the aforesaid time and place, Defendant, Robert Scott Lyons, lost control of the vehicle he was operating, crossed the line of the roadway and struck head on, a vehicle coming in the opposite direction.

7. The negligence and carelessness of the Defendant, all of which is the proximate cause of the Plaintiff's injuries hereinafter alleged, consisted of:

- (a) Operating his vehicle at an excessive rate of speed under the circumstances.
- (b) Failing to have his vehicle under proper and adequate control.
- (c) Failing to observe the oncoming vehicle traveling in the opposite direction.
- (d) Failing to keep a reasonable lookout for other vehicles lawfully on the road.
- (e) Failing to drive at a speed and in a manner that would allow him to stop within an assured clear distance ahead and prevent him from crossing the center line of the roadway.
- (f) Operating a motor vehicle while under the influence of alcohol to a degree which rendered him incapable of safe driving.
- (g) Otherwise operating said vehicle in a careless, reckless and negligent manner and in a manner violating the Motor Vehicle Code of the Commonwealth of Pennsylvania.

8. The accident was caused by the negligence and recklessness of the Defendant, Robert Scott Lyons, and in no way was caused by the Plaintiff.

9. As a result of the aforementioned accident, Plaintiff, Cynthia Ann Holliday, suffered severe, permanent,

and disabling injuries which include, but are not limited to:

- (a) Loss of Four teeth
- (b) Fractured left hand
- (c) Collapsed lung
- (d) Severe head lacerations
- (e) Significant encephalopathy secondary to a severe head injury
- (f) Organic brain syndrome secondary to severe head injury
- (g) Severe left subdural hematoma
- (h) Midline shift to the right and effacement of the occipital horn
- (i) Motor cognitive, and psychological dysfunction secondary to a severe head injury
- (j) Depressed skull fracture

10. As a result of her aforementioned injuries, Plaintiff, Cynthia Ann Holliday, has undergone in the past and will in the future, continue to undergo great pain and suffering.

11. As a result of her aforementioned injuries, Plaintiff, Cynthia Ann Holliday, has suffered a permanent disability and a permanent impairment of her earning power and capabilities.

12. As a result of her injuries, Plaintiff, Cynthia Ann Holliday, has suffered a permanent diminution in the ability to enjoy life and life's pleasures and will require future care and services.

13. As a result of her injuries, Plaintiff, Cynthia Ann Holliday, and her guardian, have incurred other medical

expenses which exceed sums recoverable under 75 PA. CS 1711. The amount of said losses which exceed benefits recoverable under 75 PA. CS 1711 are in excess of \$100,000, and are continuing.

WHEREFORE, Plaintiff, Cynthia Ann Holliday, a minor, by Gerald S. Holliday, her Guardian, demands judgment against the Defendant, Robert Scott Lyons, in the amount in excess of Ten Thousand Dollars (\$10,000.00) and in excess of the amount requiring compulsory arbitration.

/s/ Thomas G. Johnson
Thomas G. Johnson, Esquire
Attorney for Plaintiff

COMMONWEALTH OF *
PENNSYLVANIA *
* ss.
COUNTY OF INDIANA *

Before me, the undersigned authority, personally appeared Gerald S. Holliday, natural father and guardian of Cynthia Ann Holliday, the Plaintiff in the within action, who being by me duly sworn according to law, deposes and says that the averments contained in the foregoing Complaint are true and correct on personal knowledge as to those facts of which he has personal knowledge, and on information and belief as to those facts of which he does not have personal knowledge.

/s/ Gerald S. Holliday
Gerald S. Holliday,
natural father and guardian
of Cynthia Ann Holliday

Sworn to and subscribed before
me this 20th day of April, 1987.

/s/ Denise Miller-Buzzinotti

DENISE MILLER-

BUZZINOTTI

Notary Public

Indiana County, Indiana, PA

Commission Expires

July 9, 1990

A. HARKLEROAD by handing to him personally a true and correct copy of the petition for interpleader and making known to him the contents thereof at 109 Royal Garden St., Indiana, White Twp., Indiana County, PA.

September 12, 1987 at 2:25 P.M. served the within Petition for Interpleader upon EDWARD HOWELL by handing to him personally a true and correct copy of the petition for interpleader and making known to him the contents thereof at 492 East Pike, Indiana, White Twp., Indiana County, PA.

September 15, 1987 at 10:30 A.M. served the within Petition for Interpleader upon DOUGLAS B. BUSH by handing to him personally a true and correct copy of the petition for interpleader and making known to him the contents thereof at 51 S. 14th Street, Indiana Borough, Indiana County, PA.

September 16, 1987 at 1:45 P.M. served the within Petition for Interpleader upon JANE FULMER by handing to Glenn Miller, person in charge at time, a true and correct copy of the petition for interpleader and making known to him the contents thereof at R.D. #1, Creekside, Washington Twp., Indiana County, PA.

So answers,

John R. Gondal

Sheriff, Indiana County

By /s/ Norman Bruce Preite

Norman Bruce Preite,
Deputy

Sworn to and subscribed before
me this 17th day of September,
1987.

/s/ Linda J. Moore
 Prothonotary, Indiana County
 MY COMMISSION EXPIRES
 (illegible) MONDAY IN JAN-
 UARY 1988

Costs: 50.00

IN THE COURT OF COMMON PLEAS
 OF INDIANA COUNTY,
 PENNSYLVANIA
 CIVIL DIVISION

CYNTHIA ANN HOLLIDAY, a
 minor, by
 GERALD S. HOLLIDAY, her
 guardian,

Plaintiffs

-vs-

ROBERT SCOTT LYONS,

Defendant

PETITION FOR INTERPLEADER

STEWART, BELDEN AND BELDEN
 ATTORNEYS AT LAW

BELDEN BUILDING
 117 NORTH MAIN STREET
 GREENSBURG, PENNSYLVANIA 15601

As Exhibit C to the Complaint, Plaintiff attached copies of
 75 Pa. Cons. Stat. Ann. §§ 1711-1724, 1731 (Purdons 1984).

As Exhibit D to the Complaint, Plaintiff attached copies
 of 75 Pa. Cons. Stat. Ann. §§ 1701-1704 (Purdons 1984).

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

FMC CORPORATION,
A CORPORATION,

Plaintiff

VS.

CYNTHIA ANN HOLLIDAY,
AN INDIVIDUAL,

Defendant

*
*
*
* CIVIL ACTION
* NO. 88-1098
*
*
*

ANSWER AND AFFIRMATIVE DEFENSES

Defendant, Cynthia Ann Holliday, by her Attorney, Thomas G. Johnson, comes forth and hereby opposes the prayers for declaratory relief and requests that the complaint be dismissed and, in support thereof, states as follows:

ANSWER

1. The allegations set forth in paragraphs 1, 3, 4, 5, 9, 10, 11, 12, 14, 17, 18, 25, 26, 28, and 29 are admitted.

2. The allegations set forth in paragraph 2 of the complaint are denied in so far as Cynthia Ann Holliday is not an individual but rather an unemancipated minor.

3. The allegations set forth in paragraph 6 of the complaint are denied. To the contrary, FMC is not the fiduciary of the health plan and not therefore a proper party to bring this action.

4. The allegations set forth in paragraph 7 of the complaint are admitted in part and denied in part. It is

admitted that a health plan is filed with the U.S. Department of Labor. It is denied that such plan is self-funded and falls within the purview and qualifications of ERISA.

5. Denied. The allegations set forth in paragraph 8 of the complaint are denied. It is specifically denied that the health plan qualifies as an employee welfare benefit plan within the meaning of 29 U.S.C. 3 of ERISA. It is further denied that ERISA preempts state law as to prohibiting subrogation for co-pay medical providers.

6. Denied. The allegations set forth in paragraph 13 of the complaint are denied. It is specifically denied that the health plan provided approximately \$105,000.00 in benefits to cover medical expenses incurred by Ms. Holliday. To the contrary, if the health plan paid such a sum of money such payment amounts to overpayment of benefits, not subject to subrogation, and contrary to the provisions of the Pennsylvania Catastrophic Loss Fund.

7. The allegations set forth in paragraph 15 of the complaint are admitted in part and denied in part. It is admitted that the health plan provides that claims paid pursuant to the plan are subject to subrogation. It is denied that such health plan is entitled to subrogate the third party tort recovery of Ms. Holliday for the reason that such right is in violation of the Pennsylvania Motor Vehicle Financial Responsibility Act of 1984, 75 Pa. C.S.A. 1701 *et seq.*

8. That allegations set forth in paragraph 16 of the complaint are denied. It is denied that the fiduciary of the health plan has a responsibility to seek subrogation since such right is in direct violation of the Pennsylvania Motor Vehicle Financial Responsibility Act of 1984. It is also

specifically denied that the taking of a tort settlement from a catastrophically injured minor is not consistent with the orderly administration of the health plan and in accordance with the ERISA law and public policy.

9. The allegations set forth in paragraph 19 of the complaint are admitted in part and denied in part. It is admitted that the health plan has made repeated demands to subrogate and that the Attorney for Ms. Holliday has refused to accede to FMC exercise of its subrogation rights. It is denied that the only reason the Attorney for Ms. Holliday has denied such right is under Section 1720 of the Act. It is specifically asserted that in addition to Section 1720, other reasons for such denial are formed in affirmative defenses contained herein.

10. The allegations set forth in paragraph 20 of the complaint are denied for the reason that the same are arguments and inaccurate conclusions of law.

11. The allegations set forth in paragraph 21 of the complaint are denied for the reason that the same are arguments and inaccurate conclusion of law.

12. The allegations set forth in paragraph 22 of the complaint are denied for the reason that the same are arguments and inaccurate conclusion of law.

13. The allegations set forth in paragraph 23 of the complaint are denied for the reason that the same are arguments and inaccurate conclusion of law.

14. The allegations set forth in paragraph 24 are denied for the reason that the health plan is not a self-insured plan as contemplated under ERISA.

15. The allegations set forth in paragraph 27 of the complaint are denied. On the contrary, it is averred that Sections 1711, 1712, and 1715 do not specifically limit their coverage to policies provided by an insurer issuing or delivering liability insurance policies covering any motor vehicle of the type required to be registered under the Act. Any insurer who provides medical benefits are subject to the Act.

16. The allegations set forth in paragraph 30 of the complaint are denied. Sections 1711, 1712, 1715, and 1719 do specifically refer to, include, and govern health plans such as FMC's.

17. The allegations set forth in paragraph 31 of the complaint are denied for the reason that the same are arguments and inaccurate conclusions of law.

AFFIRMATIVE DEFENSES

FIRST DEFENSE

18. The complaint fails to set forth a cause of action upon which relief can be granted.

SECOND DEFENSE

19. The Court should exercise its discretion and decline to grant any declaratory relief.

THIRD DEFENSE

20. The Court lacks jurisdiction and the action should be dismissed because Plaintiff, FMC, failed to join necessary and indispensable parties.

FOURTH DEFENSE

21. The complaint should be dismissed because FMC has improperly brought a minor into said action, and excluded necessary and indispensable parties.

FIFTH DEFENSE

22. FMC should, in the alternative, not be entitled to subrogate against the third party tort claim of Ms. Holliday unless, and until settlement from the negligent tortfeasor is determined to amount to compensation for 100% of her damages.

SIXTH DEFENSE

23. FMC, in the alternative, should only be entitled to subrogate a percentage of its claim equal to the percentage of actual tort recovery in relationship to total damages proven by Ms. Holliday.

SEVENTH DEFENSE

24. The complaint for declaratory judgment should be dismissed because the Pennsylvania Motor Vehicle Financial Act of 1984, 75 Pa. C.S.A. 1701 *et seq.* specifically prohibits the right of subrogation to a medical provider who tenders benefits on a coordination of benefits basis.

EIGHTH DEFENSE

25. The complaint for declaratory judgment should be dismissed because the payment of \$105,000.00 medical

benefits was contrary to the provisions of the Catastrophic Loss Trust Fund, 75 Pa. C.S.A. 1761 *et seq.*

NINTH DEFENSE

26. The complaint for declaratory judgment should be dismissed because the claim for relief stated therein is contrary to Rule 2039 (A) (2) of the Pennsylvania Rules of Civil Procedure.

TENTH DEFENSE

27. The complaint for declaratory judgment should be dismissed as the subrogation requested is void as against public policy.

ELEVENTH DEFENSE

28. The complaint for declaratory judgment should be dismissed as the subrogation requested works an undue hardship and amounts to a forfeiture without due process of law.

WHEREFORE, Defendant, Cynthia Ann Holliday, respectfully requests that the complaint be dismissed, declaratory relief be denied, and that counsel fees and costs be awarded to Defendant.

JURY TRIAL DEMANDED.

Respectfully submitted,

Thomas G. Johnson, Esquire
The Daugherty House
824 Church Street

Indiana, Pennsylvania 15701
(412) 463-0226

Counsel for Defendant,
Cynthia Ann Holliday

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing document was served by first class, postage-prepaid mail this 21st day of July, 1988, at follows:

Charles Kelly, Esquire
Kirkpatrick and Lockhart
1500 Oliver Building
Pittsburgh, Pennsylvania 15222

By: /s/ Thomas Johnson
Thomas G. Johnson, Esquire
Attorney for Defendant,
Cynthia Ann Holliday

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF PENNSYLVANIA

FMC CORPORATION,)	
a corporation)	
Plaintiff,	)	Civil Action
	)	No. 88 1098
v.)	
CYNTHIA ANN HOLLIDAY,)	
an individual,)	
Defendant.)	

MOTION OF PLAINTIFF, FMC CORPORATION, FOR SUMMARY JUDGMENT

AND NOW COMES Plaintiff, FMC Corporation, by its attorneys, Kirkpatrick & Lockhart, and respectfully moves this Court, pursuant to Rule 56(a) of the Federal Rules of Civil Procedure, for the entry of summary judgment in favor of FMC Corporation, stating as follows:

1. FMC Corporation ("FMC") has established and maintains an employee welfare benefit plan within the meaning of ERISA Sections 3(1) and 4(a), 29 U.S.C. Sections 1002(1) and 1003(a)(1). The plan is known as the FMC Salaried Health Care Plan ("Health Plan"). The Health Plan is self insured.

2. Gerald S. Holliday ("Mr. Holliday"), the father and legal guardian of Cynthia Holliday ("Ms. Holliday"), is an employee of FMC and at all times relevant to this action subscribed to the Health Plan. Ms. Holliday is a dependent of Mr. Holliday and a beneficiary of the Health Plan.

3. On January 16, 1987, Ms. Holliday sustained serious injuries in an automobile accident and required extensive and intensive medical treatment. FMC, on Ms. Holliday's behalf, paid in excess of \$67,000 in medical benefits.

4. On April 20, 1987, Mr. Holliday, on behalf of Ms. Holliday, commenced in the Court of Common Pleas for Indiana County, Pennsylvania, a civil action (the "Indiana County action") against the driver of the vehicle who was responsible for the accident in which Ms. Holliday was injured. That action is pending.

5. The Health Plan provides, *inter alia*, that FMC's self insured benefit program is automatically assigned the right of action a subscriber to the Health Plan brings against third parties in any situation in which benefits are paid to employees or their dependents.

6. FMC, after the Indiana County action was commenced, notified counsel for the Hollidays of its intention to exercise its subrogation rights. Counsel, Thomas G. Johnson, has objected to FMC's exercise of its subrogation rights, claiming that the Pennsylvania Motor Vehicle Financial Responsibility Law of 1984 (the "Law") precludes self-insured medical providers, such as FMC, from exercising such rights.

7. FMC disagrees and now seeks the entry of summary judgment in its favor for two basic reasons:

First, the Employee Retirement Income Security Act ("ERISA") preempts the Law's anti-subrogation clause. The U.S. Supreme Court case of *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985), and its progeny,

firmly establish that a state statute regulating insurance will be preempted to the extent it is applied to a self-insured employee welfare benefit plan, such as the Health Plan. (For detailed discussion see accompanying Memorandum of FMC Corporation In Support of Motion for Summary Judgment).

Second, a careful reading of the Law demonstrates that the Pennsylvania Legislature did not intend, in drafting the Law, to deny self-insured medical providers the right to exercise subrogation rights. (See accompanying FMC Memorandum In Support).

WHEREFORE, for the reasons stated above and in the accompanying Memorandum In Support, FMC respectfully requests that this Court order the defendant and her counsel to honor FMC's contractually-provided right of subrogation and cooperate with FMC's exercise of such right. A proposed Order of Court is attached hereto pursuant to Local Rule 4(a)(2).

Respectfully submitted,

DATE:

/s/ Charles Kelly
H. Woodruff Turner, Esquire
Charles Kelly, Esquire
Kirkpatrick & Lockhart
1500 Oliver Building
Pittsburgh, PA 15222

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

FMC CORPORATION,)	
a corporation)	
Plaintiff,	)	Civil Action
	)	No. 88 1098
v.)	
CYNTHIA ANN HOLLIDAY,)	
an individual,)	
Defendant.)	

AFFIDAVIT

"I, DENESE WOJCIK, the Health Care Administrator for the FMC Salaried Health Care Plan, do hereby depose and say that the foregoing facts are true and accurate to the best of my knowledge.

/s/ Denese M. Wojcik
Denese Wojcik

SWORN TO AND SUBSCRIBED
BEFORE ME THIS 30th
DAY OF November, 1988

/s/ Laura W. Olsen
Notary Public

My Commission Expires:
Laura W. Olsen
Notary Public, Cook County, Illinois
My Commission Expires March 4, 1989

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

FMC Corporation,)	
a corporation)	
Plaintiff,	)	Civil Action
	)	No. 88-1098
v.)	
Cynthia Ann Holliday,)	
an individual,)	
Defendant.)	

ORDER OF COURT

AND NOW, this ___ day of ___, 1988, upon consideration of the Motion for Summary Judgment of FMC Corporation, it is hereby Ordered, Adjudged, and Decreed that FMC Corporation is entitled to judgment as a matter of law and that defendant, Cynthia Holliday, and her counsel, as a result, must cooperate with and otherwise facilitate FMC's exercise of its subrogation rights.

BY THE COURT:

_____J.

CERTIFICATE OF SERVICE

I hereby certify that true and correct copies of the foregoing Motion for Plaintiff, FMC Corporation, For Summary Judgment and Memorandum In Support Thereof were served on Counsel of Defendant by First Class, Prepaid Mail, this 2nd day of December, 1988:

Thomas G. Johnson, Esquire
The Daugherty House
824 Church Street
Indiana, PA 15201

/s/ Charles Kelly
Charles Kelly, Esquire
Kirkpatrick & Lockhart
1500 Oliver Building
Pittsburgh, PA 15222
(412) 355-6500

The following exhibits were attached to Plaintiff's Memorandum in Support of its Motion for Summary Judgment

Exhibit A

THOMAS G. JOHNSON
ATTORNEY AT LAW
SUITE 406 INDIANA THEATRE BUILDING
INDIANA, PENNSYLVANIA 15701
MARKET STREET
BLAIRSVILLE
MON & WED EVENINGS

TELEPHONE
AREA CODE 412
463-0226

January 19, 1988

PIMCO
One PHICO Drive
P. O. Box 85
Mechanicsburg, Pennsylvania 17055-0085

RE: Your File : 686-87-1200
Claimant : Cynthia Ann Holliday
D/O/L : 1-16-87

ATTENTION: TAMMY M. LENKER

Dear Ms. Lenker:

Enclosed please find photocopies of the following medical invoices:

Children's Hospital	\$ 33,475.11
Rehabilitation Institute	\$144,450.00
Rehabilitation Institute (leg brace)	\$ 704.00
Total	\$178,626.11

Should you need further information, please feel free to contact this office.

Yours truly,
Thomas G. Johnson

TGJ*DB

Enclosures

Exhibit B

THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

FMC Corporation,)	
a corporation)	
Plaintiff,)	
v.	)	Civil Action
	)	No. 88-1098
Cynthia Ann Holliday,)	
an individual,)	
Defendant.)	

AFFIDAVIT OF DENESE M. WOJCIK

COMMONWEALTH OF)	
PENNSYLVANIA	)	SS:
COUNTY OF ALLEGHENY)	

Before me, the undersigned notary public, this day personally appeared Denese M. Wojcik, to me known, who being duly sworn according to law, deposes and says:

1. I am the Administrator of Health Care Management at FMC Corporation ("FMC"). My office is located at 200 East Randolph Drive, Chicago, Illinois 60601. I am personally familiar with the facts contained in this affidavit. I make this affidavit in support of FMC's Motion for Summary Judgment.

2. My duties include the management of various health plans established and provided by FMC. Among those plans I supervise is the FMC Salaried Health Care

Plan ("Health Plan"). The Health Plan is filed with the U.S. Department of Labor under Plan No. PN540.

3. The Health Plan is self-insured.

4. The Health Plan is an employee welfare benefit plan within the meaning of 29 U.S.C. Sections 1002(1) and 1003(a)(1) of the Employee Retirement Income Security Act ("ERISA") since it was established and is maintained by FMC to provide beneficiaries medical, surgical and hospital care benefits in the event of sickness, accident or disability.

5. The Health Plan, in addition to providing benefits for FMC employees, also provides health care coverage for dependents of FMC employees. Those dependents include unmarried children less than 19 years old who reside in the household of an FMC employee.

6. Gerald S. Holliday ("Mr. Holliday"), the father and legal guardian of Cynthia Holliday ("Ms. Holliday"), is an employee of FMC and at all times relevant to this action subscribed to the Health Plan. Ms. Holliday is a beneficiary of the Health Plan.

7. Ms. Holliday in 1987, sustained serious injuries in an automobile accident and required medical treatment at the Children's Hospital of Pittsburgh and at the Rehabilitation Institute of Pittsburgh. FMC, on Ms. Holliday's behalf, has paid approximately \$67,768 in medical benefits for such treatment.

8. The Health Plan provides that FMC's self insured benefit program is automatically assigned the right of action a subscriber to the Health Plan brings against third

parties in any situation in which benefits are paid to employees or their dependents.

9. Upon learning that Mr. Holliday, on Ms. Holliday's behalf, had commenced a civil action in the Court of Common Pleas for Indiana County, Pennsylvania against the driver of the vehicle who was responsible for the accident in which Ms. Holliday was injured, FMC notified the Hollidays of its intention to exercise its subrogation rights with respect to the Indiana County action. Counsel for the Hollidays, Thomas G. Johnson, has objected to FMC's exercise of its subrogation rights, claiming that the Pennsylvania Motor Vehicle Financial Responsibility Law of 1984 precludes self insured medical providers, such as FMC, from exercising such rights.

/s/ Denese M. Wojcik
Denese M. Wojcik

SUBSCRIBED AND SWORN
TO BEFORE ME THIS 30th
DAY OF November, 1988.

/s/ Laura W. Olsen
Notary Public

My Commission Expires:
Laura W. Olsen
Notary Public, Cook County, Illinois
My Commission Expires March 4, 1990

Exhibit C

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

FMC CORPORATION,
A CORPORATION

Plaintiff

VS.

CYNTHIA ANN HOLLIDAY,
AN INDIVIDUAL

Defendant

CIVIL ACTION
NO. 88 1098

RESPONSE TO REQUEST FOR ADMISSIONS

1. Admitted: _____ Denied: XX

Defendant must deny this requested admission in that Exhibit A may or may not be a true and correct copy of the FMC Salaried Health Care Plan. Exhibit A purports to be a summary of such plan.

2. Admitted: XX Denied: _____
3. Admitted: _____ Denied: XX

Defendant must deny this requested admission in that Exhibit A may or may not be a true and correct copy of the FMC Salaried Health Care Plan. Exhibit A purports to be a summary of such plan.

4. Admitted: _____ Denied: XX

Defendant must deny this requested admission in that Exhibit A may or may not be a true and correct copy of the FMC Salaried Health Care Plan. Exhibit A purports to be a summary of such plan.

5. Admitted: XX Denied: _____
6. Admitted: XX Denied: _____

7. Admitted: XX Denied: _____
8. Admitted: XX Denied: _____
9. Admitted: XX Denied: _____
10. Admitted: XX Denied: _____
11. Admitted: XX Denied: _____
12. Admitted: XX Denied: _____
13. Admitted: _____ Denied: XX

This request must be denied in that although Ms. Holliday incurred, as of January 19, 1988, at least \$178,626.11 in medical bills, Defendant cannot be certain that as of that date substantially more medical expenses were incurred.

14. Admitted: XX Denied: _____
15. Admitted: XX Denied: _____
16. Admitted: _____ Denied: XX

Once again, although it would be admitted that medical benefits were paid through a health plan at FMC, it cannot be admitted that such benefits were paid through Exhibit A.

17. Admitted: XX Denied: _____
18. Admitted: XX Denied: _____
19. Admitted: XX Denied: _____

/s/ Thomas G. Johnson
Thomas G. Johnson, Esquire
824 Church Street
Indiana, Pennsylvania 15701
(412) 463-0226

Counsel for Defendant

PROOF OF SERVICE

I hereby certify that a true and correct copy of the foregoing Response to Request for Admissions was served upon Kirkpatrick and Lockhart by first class mail, postage-prepaid, on November 29, 1988.

/s/ Thomas G. Johnson
 Thomas G. Johnson, Esquire
 Attorney for
 Cynthia Ann Holliday,
 an individual

IN THE UNITED STATES DISTRICT COURT
 FOR THE WESTERN DISTRICT OF PENNSYLVANIA

FMC Corporation,)	
a corporation)	
Plaintiff,)	
v.	)	Civil Action No.
Cynthia Ann Holliday,)	
an individual,)	
Defendant.)	

PLAINTIFF, FMC CORPORATION'S, FIRST REQUEST
 FOR ADMISSIONS ADDRESSED TO DEFENDANT,
 CYNTHIA HOLLIDAY

Pursuant to Rule 36(a) of the Federal Rules of Civil Procedure Defendant, Cynthia Ann Holliday, is hereby required to answer the following Requests for Admissions, in writing, under oath, within ten (10) days hereof, to file such answers with the District Court for the Western District of Pennsylvania, and to serve a copy of such answers on Charles Kelly, Kirkpatrick & Lockhart, 1500 Oliver Building, Pittsburgh, PA 15222.

Definitions and Instructions

1. "Ms. Holliday" refers to the defendant, Cynthia Ann Holliday.
2. "Mr. Holliday" refers to Gerald S. Holliday, the father of Ms. Holliday.
3. "FMC" refers to the plaintiff, FMC Corporation.
4. In answering these Requests for Admissions please furnish not only such information as is available to

the particular individual or individuals answering them, but also such information as is known to any guardian, representative, or agent of Ms. Holliday.

5. If the person or persons answering these Requests for Admissions are unable to answer any of them completely after exercising due diligence to secure the necessary information, such person or persons should answer each Request for Admission to the fullest extent possible.

6. These Requests for Admissions are continuing. In the event that any information comes to the attention of Ms. Holliday after she files her answers that is responsive to a Request for Admission, or which would change in any way a response, such additional information must be furnished to FMC's attorneys without further request.

Requests

1. Exhibit A attached hereto is a true and correct copy of the FMC Salaried Health Care Plan ("the Health Plan").

2. Mr. Holliday is an employee of FMC.

3. Mr. Holliday, during his employment, has subscribed to the Health Plan.

4. The Health Plan, in addition to providing benefits for FMC employees, also provides health care coverage for the dependents of FMC employees.

5. Ms. Holliday was injured in an automobile accident in White Township, Indiana County, Pennsylvania on January 16, 1987.

6. As a result of the accident, Ms. Holliday suffered severe injuries.

7. As a result of the accident, Ms. Holliday required medical treatment.

8. Ms. Holliday received medical treatment at Children's Hospital of Pittsburgh ("Children's Hospital"), 3705 Fifth Avenue at Desoto St., Pittsburgh, PA.

9. Ms. Holliday received medical treatment at The Rehabilitation Institute of Pittsburgh ("Rehabilitation Institute"), 6301 Northumberland Street, Pittsburgh, PA.

10. Ms. Holliday's attorney in this matter is Thomas G. Johnson ("Johnson").

11. Attached Exhibit B is a true and correct copy of a letter from Johnson to the Pennsylvania Insurance Management Company ("PIMCO").

12. Exhibit B was produced pursuant to a document request served by FMC on Ms. Holliday.

13. Ms. Holliday, by January 19, 1988, had incurred medical expenses of \$178,626.11.

14. Ms. Holliday, at the time of the 1987 accident, was a dependent of Mr. Holliday.

15. Ms. Holliday, at the time of receiving medical treatment from Children's Hospital and the Rehabilitation Institute, was a dependent of Mr. Holliday.

16. The Health Plan has provided benefits in connection with the medical expenses incurred by Ms. Holliday.

17. Attached Exhibit C is a true and correct copy of an FMC Third Party Reimbursement form completed, in part, by Johnson.

18. The signature appearing in Exhibit C above the language "Signature of Employee" is that of Mr. Holliday.

19. The signature appearing in Exhibit C was made on February 20, 1987.

Dated: November 15, 1988

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing First Request for Admissions Addressed to Defendant, Cynthia Holliday was served on Counsel of Defendant, by Purolator Courier Mail, this 15th day of November, 1988:

Thomas G. Johnson, Esquire
The Daugherty House
824 Church Street
Indiana, PA 15201

/s/ Charles Kelly
Charles Kelly, Esquire

As Exhibit A to Plaintiff's First Request for Admissions Addressed to Defendant, Plaintiff attached a copy of the FMC Salaried Health Care Plan. This copy has been printed at pages 12 to 79, *infra*.

THOMAS G. JOHNSON
ATTORNEY AT LAW
SUITE 406 INDIANA THEATRE BUILDING
INDIANA, PENNSYLVANIA 15701

MARKET STREET
BLAIRSVILLE
MON & WED EVENINGS

TELEPHONE
AREA CODE 412
463-0226

January 19, 1988

PIMCO
One PHICO Drive
P. O. Box 85
Mechanicsburg, Pennsylvania 17055-0085

RE: Your File : 686-87-1200
Claimant : Cynthia Ann Holliday
D/O/L : 1-16-87

ATTENTION: TAMMY M. LENKER

Dear Ms. Lenker:

Enclosed please find photocopies of the following medical invoices:

Children's Hospital	\$ 33,475.11
Rehabilitation Institute	\$144,450.00
Rehabilitation Institute	\$ 704.00
(leg brace)	
Total	\$178,626.11

Should you need further information, please feel free to contact this office.

Yours truly,

Thomas G. Johnson

TGJ*DB
Enclosures

EXHIBIT B TO PLAINTIFF'S FIRST
REQUEST FOR ADMISSIONS

GENERAL LIABILITY

FMC Corporation
200 East Randolph Drive
Chicago, Illinois 60601

Third Party Reimbursement

Name: Gerald S. Holliday

Location: White Twp., Indiana County, PA.

Social Security No.: _____

1. Benefit Plan Number: ____ Branch: ____ Location ____
2. Date of accident Jan. 18th 1987
Time of accident 2315 Hours
Were police or emergency units called? Yes
If called, please identify. Ambulance, PA. State Police
(Trp. George A. Kuzilla)
3. Location of accident (in detail) See attached police report
4. Description of Accident See attached police report
5. Name and address of the person or persons who caused the loss or are responsible.
Robert Scott Lyons
941 McHenry Road, Indiana, PA. 15701
6. Name, address, and telephone number of responsible parties' insurance company.
Celina Insurance Group
Bill Lewis, Adjuster
Box 396 Martinsburg, PA.
7. The name, address, and telephone number of your attorneys.
Thomas G. Johnson
Suite 406 Ind. Theatre Bldg.
Indiana, PA. 15701

**EXHIBIT C TO PLAINTIFF'S
FIRST REQUEST FOR ADMISSIONS**

8. Name, address, and telephone number of responsible party's attorney (if available).
Not available
 9. Will suit or claim be made against the responsible party? yes
If not, please explain why. _____
 10. Other comments. _____
- Signed: _____ Date: _____

FMC CORPORATION

Third Party Reimbursement Notification

The Plan of Benefits provided by FMC Corporation includes a third party reimbursement provision.

As a condition of eligibility to receive benefits under the Plan, each covered person (including the employee on his own behalf; and on behalf of his dependents) agrees that the Company shall be reimbursed to his rights to recovery of damages, to the extent benefits are provided under the Plan, for illness or injury of himself or of any covered person which is caused by the alleged negligence of any third person, and assigns to the Company such cause of action.

In the event that any Covered Person must accept personal responsibility for or contract to pay his own special damages in order to recover them from such third person, he hereby accepts such personal responsibility and makes such contract to the extent necessary to make assignment to the Company effective and valid.

I, , hereby agree, for myself, my heirs, executors, administrators and assigns, to reimburse the Equitable Life Assurance Society of the United States for any amounts which I may receive for myself or on behalf of my eligible covered dependents under the Plan for bodily injuries or sickness for which claim has been submitted. If I bring a liability claim against any third party, benefits payable under this Plan must be included in the claim, and when the claim is settled I must reimburse the Plan for the benefits provided. I am obligated to avoid doing anything which would prejudice the Plan's rights of reimbursement, and I understand that I may be required to

sign and deliver documents to evidence or secure those rights.

Such reimbursement shall be limited to benefits paid under the Plan but in no event in an amount in excess of the proceeds of any such recovery after the deduction of reasonable and necessary expenditures, including attorney's fees, incurred in effecting such recovery.

Gerald S. Holliday
Employee Name
(Print)

X /s/ Gerald S. Holliday
Signature of Employee

Social Security No.
X 186 36 5603

Signature of Patient
(if not employee)

Signature of Witness

X 2/20/87
Date

EXHIBIT DIN THE COURT OF COMMON PLEAS OF
INDIANA COUNTY, PENNSYLVANIA

CIVIL DIVISION

CYNTHIA ANN	)	Date Filed _____
HOLLIDAY, a)	
minor, by	)	No. 535 C.D. 1987
GERALD S.)	
HOLLIDAY,)	
her guardian,)	
)	
Plaintiffs)	
-vs-	)	Type of Pleading:
	)	PETITION FOR INTERPLEADER
ROBERT)	
SCOTT LYONS,)	
Defendant)	

Counsel for This Party:

GERALD J. YANITY, Esquire
PA I. D. No. 22067

STEWART, BELDEN and
BELDEN

Attorneys at Law
Belden Building
117 North Main Street
Greensburg, PA 15601
(412) 834-0300

Attorneys for Defendant

IN THE COURT OF COMMON PLEAS OF
WESTMORELAND COUNTY, PENNSYLVANIA

CIVIL DIVISION

CYNTHIA ANN HOLLIDAY, a)	
minor, by)	
GERALD S. HOLLIDAY, her)	
guardian,)	
)	
Plaintiffs)	
-vs-	)	No. 535 C.D.
	)	1987
ROBERT SCOTT LYONS,)	
Defendant)	

PETITION FOR INTERPLEADER

TO THE HONORABLE, THE JUDGES OF SAID COURT:

The Petition of ROBERT SCOTT LYONS, by and through his counsel, Stewart, Belden and Belden, respectfully represents:

1. ROBERT SCOTT LYONS is the defendant in this action.
2. The action was commenced by a Complaint filed at the above number and term on April 21, 1987, alleging, inter alia, that on January 16, 1987, your petitioner negligently operated a motor vehicle, causing it to strike another motor vehicle, wherein the minor plaintiff, Cynthia Ann Holliday, was injured. The plaintiffs allege that her damages are in excess of One Hundred Thousand (\$100,000.00) Dollars.
3. Your petitioner has been advised that Clay Harkleroad, a passenger in the other vehicle involved in the

accident, has made a claim or demand against him for injuries arising out of the same accident, which claim may be inconsistent with the cause of action asserted by the plaintiffs.

4. Your petitioner expects that Douglas B. Bush, a passenger in his automobile at the time of the accident, and Mark Edward Howell, the operator of the other motor vehicle involved in the accident, as well as Mary Jane Fulmer, a passenger in said other motor vehicle (all of who were injured in the accident of January 16, 1987), will also make demands or claims against him for injuries or damages arising out of the accident which may be inconsistent with the cause of action asserted by the plaintiffs.

5. The assertion of the claim by Clay Harkleroad, as well as the expected claims by Douglas B. Bush, Mary Jane Fulmer and Mark Edward Howell, may expose your petitioner to multiple liability in that his insurance coverage has a single limit of One Hundred Thousand (\$100,000.00) Dollars, and all of the claims or demands against him, or expected to be made against him, will exceed that amount.

6. This Petition is filed in good faith and not in collusion with any party to this action or with the plaintiffs.

7. Your petitioner claims no interest in the amount in controversy, and is willing to pay his insurance policy limits into Court, or to such person as the Court may direct.

8. Your petitioner has not admitted the claim of, or subjected himself to independent liability to, the plaintiffs, or any claimant, in respect to the subject matter of the action.

WHEREFORE, your petitioner respectfully asks that the Court order all of the above claimants or expected claimants to interplead, and to stay all proceedings meanwhile, pursuant to the provisions of PA R.C.P. 2303.

Respectfully submitted,

STEWART, BELDEN and BELDEN

By /s/ Gerald J. Yanity
Attorneys for Defendant

Belden Building
117 North Main Street
Greensburg, PA 15601
(412) 834-0300

A F F I D A V I T

COMMONWEALTH)
 OF PENNSYLVANIA)
) SS:
 COUNTY OF)
 WESTMORELAND)

Before me, the undersigned authority in and for said County and Commonwealth, personally appeared ROBERT SCOTT LYONS, within petitioner, who, being duly sworn according to law, deposes and says that the facts set forth in the foregoing Petition for Interpleader are true and correct to the best of his knowledge, information and belief.

/s/ Robert Scott Lyons
 Robert Scott Lyons

SWORN to and subscribed
 before me this 11th
 day of August,
 1987.

/s/ Henrietta C. Rutledge
 Notary Public

My Commission Expires:
 HENRIETTA C. RUTLEDGE
 NOTARY PUBLIC
 WESTMORELAND CO. PENNA
 COMMISSION EXPIRES 3 July 1988

IN THE COURT OF COMMON PLEAS OF
INDIANA COUNTY, PENNSYLVANIA

CIVIL DIVISION

CYNTHIA ANN HOLLIDAY,)	
a minor, by)	
GERALD S. HOLLIDAY, her)	
guardian,)	
)	
Plaintiffs	)	No. 535 C.D.
-vs-	)	1987
ROBERT SCOTT LYONS,)	
)	
Defendant)	
)	

ORDER OF COURT

AND NOW, This 3rd day of SEPTEMBER, 1987, the Petition of **ROBERT SCOTT LYONS** is granted and **DOUGLAS B. BUSH, MARY JANE FULMER, CLAY A. HARKLEROAD** and **MARK EDWARD HOWELL** are added to the record as party plaintiffs and are enjoined from commencing or further prosecuting any action in any court against **ROBERT SCOTT LYONS** to enforce in whole or in part any claim or claims against him set forth in said Petition, except as a party or parties to the above entitled action.

NOW, THEREFORE, we command you, the Sheriff of the County of Indiana, Commonwealth of Pennsylvania, to direct the claimants, **DOUGLAS B. BUSH**, 51 South 14th Street, Indiana, Pennsylvania, 15701; **MARY JANE FULMER**, R. D. #1, Creekside, Pennsylvania, 15732;

CLAY A. HARKLEROAD, 109 Royal Garden Court, Indiana, Pennsylvania, 15701; and **MARK EDWARD HOWELL**, 492 East Pike, Indiana, Pennsylvania, 15701, to file in the above entitled action in the office of the Prothonotary of the Court of Common Pleas of Indiana County, Pennsylvania, Civil Division, a complaint within twenty (20) days after being served with copies of the Petition for Interpleader and this Order and all pleadings heretofore filed in the above entitled action if said service was made within your County, or within thirty (30) days of said service if said service was made within any other county of this Commonwealth.

BY THE COURT:

/s/ Robert Earley

Judge

ATTEST:

As Exhibit E to Plaintiff's Memorandum in Support of Its Motion for Summary Judgment, Plaintiff attached a copy of 75 Pa. Cons. Stat. Ann. §§1703-1704, 1711-1724, 1731 (Purdons 1984).

As Exhibit F to Plaintiff's Memorandum in Support of Its Motion for Summary Judgment, Plaintiff attached a copy of 75 Pa. Cons. Stat. Ann. §§1701-1704 (Purdons 1984).

As Exhibit G to Plaintiff's Memorandum in Support of Its Motion for Summary Judgment, Plaintiff attached a copy of Sections 111 and 203 of Pennsylvania's No-Fault Act, 40 P.S. §§111, 203.

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CIVIL ACTION
NO.
88 1098

Defendant, Cynthia Ann Holliday, by her Attorney, moves this Court, pursuant to Rule 56 of the Federal Rules of Civil Procedure for Summary Judgment in favor of the Defendant and against the Plaintiff, FMC Corporation, a corporation. In support of this Motion, Defendant relies on the pleadings filed in this matter and the anticipated response from Plaintiff to Request for Admissions, and avers as follows:

1. On January 16, 1987, Cynthia Ann Holliday, a minor and natural child of Gerald Holliday, was seriously injured in an automobile accident in Indiana County, Pennsylvania.

2. On October 1, 1984, the Pennsylvania Motor Vehicle Financial Responsibility Law, 75 Pa. C.S.A. 1701, *et seq.* went into effect which provided under Section 1720:

In action arising out the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a Claimant's

tort recovery with respect to. . . , or benefits in lieu thereof paid or payable under Section 1719 (relating to coordination of benefits).

3. At the time of the aforesaid accident, Gerald Holliday was employed by FMC Corporation and enrolled in the FMC Health Plan.

4. FMC Corporation and the FMC Health Plan, under its own contractual terms, had the obligation to provide health benefits to Cynthia Ann Holliday for medical services occasioned by her injuries.

5. FMC Corporation and the FMC Health Plan, accepted the jurisdiction of, and derived the benefits from, the Pennsylvania Motor Vehicle Financial Responsibility Law, 75 Pa. C.S.A. Section 1711 (relating to required benefits) by requiring State Farm Mutual Insurance Company to pay the first \$10,000.00 of medical expenses incurred by Cynthia Ann Holliday.

6. FMC Corporation and the FMC Health Plan, accepted the jurisdiction of and derived the benefits from the Pennsylvania Motor Vehicle Financial Responsibility Law 75 Pa. C.S.A. Section 1713 (relating to source of benefits) by requiring State Farm Mutual Insurance Company to pay the first \$10,000.00 of medical expenses incurred by Cynthia Ann Holliday.

7. FMC Corporation and the FMC Health Plan, accepted the jurisdiction of and derived the benefits from the Catastrophic Loss Trust Fund, 75 Pa. C.S.A. Section 1761 *et seq.* by avoiding payment of all medical expenses of Cynthia Ann Holliday which were in excess of \$100,000.00 or by requesting repayment from the Fund

for any bills paid by them which were in excess of \$100,000.00.

8. As a matter of law, by availing themselves of the jurisdiction and benefits of the aforementioned provisions of Pennsylvania Law, FMC Corporation and the FMC Health Plan have waived their right to seek Federal Preemption of other provisions under such law that they wish to disregard, namely the prohibition against subrogation found in 75 Pa. C.S.A. Section 1720.

9. There are no genuine issues of material fact and Defendant is entitled to judgment as a matter of law.

10. Defendant Cynthia Ann Holliday reserves the right to file a Supplemental Motion for Summary Judgment and Brief in Support thereof upon receipt of Plaintiff's Response to Requested Admissions and Response to Request for Documents.

WHEREFORE, Defendant requests that this Honorable Court enter Summary Judgment in favor of the Defendant declaring that FMC Corporation and the FMC Health Plan is not entitled to subrogate against the third-party tort claim of Cynthia Ann Holliday.

Respectfully submitted,

/s/ Thomas G. Johnson
Thomas G. Johnson, Esquire
Attorney for Defendant

PROOF OF SERVICE

I hereby certify that a true and correct copy of the foregoing Motion for Summary Judgment was served upon Charles Kelly, Esquire of Kirkpatrick and Lockhart, 1500 Oliver Building, Pittsburgh, Pennsylvania 15222-5379, by first class mail, postage prepaid, on December 2, 1988.

/s/ Thomas G. Johnson
Thomas G. Johnson, Esquire
Attorney for Cynthia Ann
Holliday

The following exhibits were attached to Defendant's Memorandum in Support of Its Motion for Summary Judgment.

As Exhibit A to Defendant's Memorandum in Support of Its Motion for Summary Judgment, Defendant attached a copy of 75 Pa. Cons. Stat. Ann. §§1703-1704, 1711-1724 (Purdons 1984).

Exhibit "B"

PAYMENT TRANSMITTAL

✓ -	STATE FARM MUTUAL AUTO-MOBILE INSURANCE COMPANY	-	STATE FARM LLO
	NY	-	STATE FARM COUNTY MUTUAL INSURANCE COMPANY OF TEXAS
(SEAL) -	STATE FARM FIRE AND CASUALTY COMPANY		
-	STATE FARM GENERAL INSURANCE COMPANY		

DATE	INSURED	DATE OF ACCIDENT OR OCCURRENCE	CLAIM NUMBER
2/6/87	Holliday, Gerald	1/16/87	38-1522-712

Gerald Holliday
1569 Church St.
Indiana, PA 15701

From:
STATE FARM INSURANCE CLAIM OFFICE
389 NEW CASTLE ROAD
P. O. BOX 2189
BUTLER, PA 16003

For Cynthia Holliday

By: /s/ Erny Wilson

Fold _

Payment for items listed below has been sent to the provider.

✓ Here is our payment for the items listed below.

Please keep this letter as your record of payments made.

Item	Amount Paid At This Time	Amount Paid Previously	Total Paid To Date
Citizens Ambulance	\$220.00	\$_____	\$_____
Indiana Hospital	\$894.90	\$_____	\$_____
TOTAL	\$1114.90	\$_____	\$1114.90

Payments made are subject to the Company's right of subrogation or reimbursement.

7. All documents require your completion of the attached Proof of Claim on (DATE)

- Complete this form and return in the enclosed postage paid return envelope.

Remarks:

PAYMENT TRANSMITTAL

✓ - STATE FARM MUTUAL AUTO-
MOBILE INSURANCE COMPA-
NY

(SEAL) - STATE FARM FIRE AND CASU-
ALTY COMPANY

- STATE FARM MUTUAL IN-
SURANCE COMPANY OF TEXAS

- STATE FARM LLO

- STATE FARM GENEKAL IN-
SURANCE COMPANY

DATE	INSURED	DATE OF ACCIDENT OR OCCURRENCE	CLAIM NUMBER
3/3/87	Holliday, Gerald & Karen	1/16/87	38-1522-712

Gerald Holliday
1569 Church St.
Indiana, PA 15701

For Cynthia Holliday

By: /s/ Erny Wilson

Fold

Payment for items listed below has been sent to the provider.

✓ Here is our payment for the items listed below.

Please keep this letter as your record of payments made.

Item	Amount Paid At This Time	Amount Paid Previously	Total Paid To Date
Illegible	\$246.75	\$	\$
S.R.T. Radiologists	\$1,295.00	\$	\$
Illegible	\$680.00	\$	\$
Illegible	\$113.00	\$	\$
TOTAL	\$2,334.75	\$1,114.90	\$3,449.65

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- Payments made are subject to the Company's right of subrogation or reimbursement.
- Further payments require your completion of the attached Proof of Claim on (DATE)
- Complete this form and return in the enclosed postage paid return envelope.

Remarks: Please Pay Illegible and SRT Radiologists

PAYMENT TRANSMITTAL

✓ STATE FARM MUTUAL AUTO-
MOBILE INSURANCE COMPA-
NY

(SEAL) - STATE FARM FIRE AND CASU-
ALTY COMPANY

- STATE FARM GENERAL IN-
SURANCE COMPANY

- STATE FARM LLO

- STATE FARM COUNTY MUTUAL IN-
SURANCE COMPANY OF TEXAS

DATE	INSURED	DATE OF ACCIDENT OR OCCURRENCE	CLAIM NUMBER
2/6/87	Holliday, Gerald & Karen	1/16/87	38-1522-712

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Gerald Holliday
1569 Church St.
Indiana, PA 15701

From:
STATE FARM INSURANCE CLAIM OFFICE
389 NEW CASTLE ROAD
P. O. BOX 2189
BUTLER, PA 16003

For Cynthia Holliday

By: /s/ Erny Wilson

Fold

- Payment for items listed below has been sent to the provider.

✓ Here is our payment for the items listed below.

Please keep this letter as your record of payments made.

Item	Amount Paid At This Time	Amount Paid Previously	Total Paid To Date
Childrens Hospital	\$6,550.35	\$3,449.65	\$10,100.00
99 State Farm's benefit applies		\$	\$
TOTAL	\$	\$	\$

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- Payments made are subject to the Company's right of subrogation or reimbursement.

- Further payments require your completion of the attached Proof of Claim on (DATE)

- Complete this form and return in the enclosed postage paid return envelope.

Remarks: illegible

EXPLANATION OF BENEFITS PROVIDED BY YOUR GROUP MEMBERSHIP

LOCATION: HOMER CITY NO: 70135 0006 G
FMC CORPORATION NAME: HOLLIDAY, GERALD
ID NUMBER: 186365603 DEPENDENTS NAME: CYNTHIA
RELATIONSHIP: CHILD CL BR: 5 DATE: MAY 1, 1987
Illegible: 518 CLAIM NUMBER: 870501 1524129 FOR INFORMATION CALL: 2907

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Type Of Expense Or Name Of Provider	Period From Through	Charges	At 90%	Benefits	See Below
INTENSIVE CARE	01/17-01/21/87	3980.00	3980.00		
SEMI-PRIVATE ROOM	01/22-02/02/87	6540.00	6540.00		
TOTAL CHARGES		10520.00	10520.00		

BENEFIT
DUPLICATE COVERAGE ADJUSTMENT

9468.00
-9468.00

NET BENEFIT

.00

STATE FARM'S BENEFIT APPLIED.

- ANOTHER EXPLANATION OF BENEFITS WILL FOLLOW. THANK YOU.

037-3-007327

5-5-87

Ardyce:

Please review the attached, the prior payment by State Farm was not to Children's hospital, it was to several other providers as noted on the payment statement. These other bills were submitted directly to and paid by State Farm in the amount of \$3,449.65, thus shouldn't you pay more directly to Children's hospital and give amount payee the necessary credit on the noted billings for the \$3,449.65.

/s/ Sharon

LOCATION'S COPY

THE EQUITABLE LIFE ASSURANCE SOCIETY
AS CLAIMS ADMINISTRATOR

(SEAL)

Date: _____

Employer: FMC Corporation
 Plan No.: 755307
 Branch No.: 2A
 Social Security No.: Illegible
 Employee: Gerald Holliday
 Patient: Cynthia
 Date of Accident: Illegible

Provider of Service	Date of Service	Total Charge	Benefits Paid
Pitts. Radiology Assoc.	2/4/87	\$ 68.00	\$ 61.20
Childrens Hosp. - Pitts.	2/16/87	43.00	43.00
Univ. Surg. Assocs.	1/17/87	1,051.00	1,051.00
Rehab. Inst. - Pitts.	2/2-2/28/87	18,225.00	18,225.00
Childrens Hosp. - Pitts.	1/17-2/2/87	10,620.00	.00
Childrens Hosp. - Pitts.	1/17-2/2/87	18,364.00	17,390.89
Univ. Neuros. Assoc.	1/17-2/1/87	520.00	520.00
SRT Radiologists	2/18/87	160.00	160.00
Radiologic Illegible	1/17/87	46.00	46.00
Childrens Hosp. - Pitts.	3/16/87	43.00	43.00
Childrens Hosp. Pitts.	4/27/87	125.00	125.00
Illegible	1/18/87	330.00	330.00
Childrens Hosp. - Pitts.	2/1-2/2/87	4591.02	4591.02
Childrens Hosp. - Pitts.	2/18/87	892.00	892.00
Childrens Hosp. - Pitts.	1/87-2/87	10520.00	3350.00
Rehab. Inst. - Pitts.	3/5/87	731	731
Indiana Hosp.	1/17/87	Illegible	Illegible
Rehab Inst. - Pitts.	3/1-4/30/87	9450.00	5737.50
Childrens Hosp. - Pitts.	9/21/87	47.00	47.00
Totals		76,765.01	53,427.61

As Exhibit C to Defendant's Memorandum in Support of Its Motion for Summary Judgment, Defendant attached copies of 75 Pa. Cons. Stat. Ann. §§1757, 1761-1765 (Purdons 1984).
